Medicine as a Public Calling

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The debate over how to tame private medical spending tends to pit advocates of government-provided insurance—a single-payer scheme—against those who would prefer to harness market forces to hold down costs. When it is mentioned at all, the possibility of regulating the medical industry as a public utility is dismissed as a political impossibility—or, worse, as anathema to the American regulatory tradition. Yet there is a rich history in the United States of subjecting private businesses that wield undue power to economic regulation. Growing out of an ancient common law practice of imposing special duties on innkeepers and common carriers, the regulation of "public callings" had evolved by the early twentieth century into a comprehensive challenge to the principles of laissez faire.

The rise of the modern medical industry in the years after the Second World War prompted the enactment of federal and state laws emerging from this tradition and directed at the business of medicine. Although the last two decades of the twentieth century saw many of these laws give way to a resurgent belief that market forces ought to guide the distribution of health-care services, an important strain of the law continues to treat medicine as a public calling. Now that the Affordable Care Act has eased concerns about the uninsured, a stubborn set of economic problems in the medical industry—supply imbalances, access restrictions, and abusive and discriminatory pricing—may spur renewed interest in laws reflecting the principles of public utility regulation. Indeed, nascent interest in such laws suggests that we may already be heading that direction.

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The debate over how to tame private medical spending tends to pit advocates of government-provided insurance—a single-payer scheme—against those who would prefer to harness market forces to hold down costs. When it is mentioned at all, the possibility of regulating the medical industry as a public utility is usually dismissed as a political non-starter.[1]

[1] *See, e.g.*, Elisabeth Rosenthal, *Health Care's Road to Ruin*, N.Y. TIMES, Dec. 21, 2013 (stating that regulating medicine as a public utility "is not politically acceptable here"); Uwe Reinhardt, *The Many Different Prices Paid to Providers and the Flawed Theory of Cost Shifting: Is It Time for a More Rational All- Payer System?*, 30 HEALTH AFF. 2125, 2130 (2011) (observing that talk of rate-setting may appear "highly controversial and revolutionary"); *cf.* Ryan Bubb & Richard H. Pildes, *How Behavioral Economics Trims Its Sails and Why*, 127 HARV. L. REV. 1593, 1596 (noting widespread assumption "that the chastened, post-New Deal political era in which we live makes unlikely sufficient political support for interventions that are not 'choice-preserving'").

However common it may be in other countries, treating the health-care sector as a public utility is thought to be anathema to American political traditions that valorize patient choice and physician independence, treat hospitals as charities, and are suspicious of state interference in economic affairs.[2]

Missing from this conventional account is the pivotal role that public utility regulation has played in the development of the modern regulatory state. Missing, too, is an appreciation of how extensively such regulation—both for good and ill—has shaped health law. Growing out of an ancient common law practice of imposing special obligations on innkeepers and common carriers, public utility regulation evolved during the Gilded Age and the Progressive Era into a comprehensive challenge to the principles of laissez faire.[3] Such regulation was originally justified—and insulated from constitutional attack—by a developing body of law governing those private businesses that were "affected with a public interest." Such businesses could not make unfettered use of their private property; instead, the law imposed on them "an affirmative obligation … to be reasonable in dealing with the public."[4] In an influential 1911 treatise, Bruce Wyman divided that affirmative obligation into four distinct duties: "that all must be served, adequate facilities must

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[2] *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 28 (1982) (charting how physicians established their professional authority with the public and used that authority in the twentieth century as "the ground for resistance to government").

[3] *See* BARBARA H. FRIED, THE PROGRESSIVE ASSAULT ON LAISSEZ FAIRE 161 (1998) ("To the contemporary eye, wont to view the field as the province of bureaucrats and technically-minded economists, the progressive romance with public utilities may be hard to fathom. [But] it reflected the philosophical and political significance of public utilities in establishing the limits of government control of business."); William J. Novak, *The Public Utility Idea and the Origins of Modern Business Organization*, in THE CORPORATION AND AMERICAN DEMOCRACY __ (Naomi Lamoreaux & William J. Novak, eds., forthcoming 2014) ("Quite simply, public utility took over turn-of-the-century statute books, commission reports, and court records. And it dominated the period's legal output: legislative, administrative, as well as judicial.").

[4] Wolff Packing Co. v. Industrial Court, 262 U.S. 522, 536 (1923).

be provided, reasonable rates must be charged, and no discriminations must be made."[5]

Businesses affected with a public interest were variously described as "public callings," "public service corporations," and "public utilities." They included not only natural monopolies like railroads, ferries, telegraph lines, electric plants, and water works, but also banks, insurance companies, housing interests, stockyards, and mines.[6] Any industry that served an important human need and had the market power to exploit consumers could plausibly be characterized as a public utility. As J. Willard Hurst explained, "[t]he public utility concept rests on recognition that some economic power is wielded at key points of intersection of human relations" and that the law must constrain the behavior of those "new forms of organized power, characterized by great aggregations of capital and great capacity to affect life."[7]

Prior to the Second World War, medicine was typically missing from even the most capacious lists of industries affected with a public interest. Yet that says more about the rudimentary state of medicine than it does about the acceptability of regulating health care as a utility. The private hospital industry was still in its infancy well into the Progressive Era, and hospitals were only slowly shedding their traditional roles as charity wards for the dying sick. By today's standards, they remained technologically unsophisticated and relatively cheap. For their part, physicians were independent professionals who sold personal services, not industrialists who put private property to public use. The absence of proven therapies for most illnesses kept medical expenditures in check, as

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[5] BRUCE WYMAN, THE SPECIAL LAW GOVERNING PUBLIC SERVICE CORPORATIONS AND ALL OTHERS ENGAGED IN PUBLIC EMPLOYMENT, VOL. I., at xi (1911).

[6] *See* Noble State Bank v. Haskell, 219 U.S. 104 (1911) (banks); German Alliance Insurance Co. v. Lewis, 233 U.S. 389 (1914) (insurance companies); Block v. Hirsh, 256 U.S. 135, 156 (1921) (housing interests); Stafford v. Wallace, 258 U.S. 495, 516 (1922) (stockyards); Strickley v. Highland Boy Gold Mining Co., 200 U.S. 527 (1906) (mines).

[7] James Willard Hurst, *Problems of Legitimacy in the Contemporary Legal Order*, 24 OKLA. L. REV. 224, 226 (1971).

did the competitive, even cutthroat, market for physicians that prevailed in the early decades of the twentieth century.

As Wyman observed, however, any given industry might fall in and out of the legal category of public callings.[8] And in the decades following the Second World War, the meteoric growth of the medical industry prompted the enactment of federal and state laws that bore the hallmarks of public utility regulation. Collectively, they regulated market entry, imposed service obligations, prohibited certain forms of price discrimination, and even fixed prices. In the last decades of the twentieth century, some of these laws gave way in the face of the resurgent belief that market forces, not state control, ought to guide the distribution of health-care services. But a durable strain of the law has always treated modern medicine as a public calling—even today.

The fit is natural. Public utility regulation aims to address the sorts of problems in market ordering—supply imbalances, access restrictions, and abusive and discriminatory pricing—that have long afflicted the medical industry. Now that the Affordable Care Act (ACA) has eased public concerns about the uninsured, the serious economic challenges facing those with insurance are likely to become more salient. Should the ACA fail to remedy a number of disturbing practices in the medical marketplace, policymakers may find public utility regulation increasingly attractive. Indeed, nascent interest in such laws suggests that we may already be heading that direction.

The possibility of regulating medicine as a public utility has not passed altogether unnoticed;[9] indeed, talk of such regulation was not

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[8] WYMAN, *supra* note 5, at x ("What branches of industry will eventually be of such public importance as to be included in the category … it would be rash to predict.").

[9] *See, e.g.*, A.J.G. Priest, *Possible Adaptation of Public Utility Concepts in the Health Care Field*, 35 L. & CONTEMP. PROBS. 839 (1970); Roger Colton et al., *Lessons for the Health Care Industry from America's Experience with Public Utilities*, 18 J. PUBLIC HEALTH POL'Y 389 (1997). As some commentators have noted, the ACA in some respects regulates health *insurance*—but not the health-care industry as a whole—as a public utility. *See, e.g.*, Richard A. Epstein & Paula M. Stannard, *Constitutional Ratemaking and the Affordable Care Act: A New Source of Vulnerability*, 38 AM. J. L. & MED. 243, 262-63 (2012).

uncommon in the 1960s and 1970s.[10] For at least three reasons, however, few recall how deeply the public utility model once influenced medical regulation and fewer still appreciate how it continues to shape such regulation today.

First, the idea of public utility regulation seems stale.[11] In part, this is a legacy of the modern law-and-economics movement, which has subjected public utility regulation to withering criticism.[12] Deregulation of the airline and trucking industries reinforced the idea that the public utility model, outside a few narrow enclaves, ought to be abandoned.[13] As Barbara Fried explains, modern economists can find "no justification for expanding the lessons of public utility regulation beyond public utilities and other formal or natural monopolies."[14] The ascendance of economics as a discipline—and its particular influence in health policy—may have obscured the influence of the public utility model on health law.[15]

Second, the law of public callings is often thought to do little more than impose on certain businesses a duty to serve all paying customers. In

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[10] *See* Roger Noll, *The Consequences of Public Utility Regulation of Hospitals*, in INSTITUTE OF MEDICINE, CONTROLS ON HEALTH CARE (1975) ("[S]erious demands have been made [since the mid-1960s] to subject the industry to 'public utility' regulation.").

[11] *See* Novak, *supra* note 3, at __ ("[F]or all intents and purposes, today, [the public utility idea] has almost disappeared—erased from all but the most specialized historical memory. What was once at the forefront of law, economics, and public policy discussion has been relegated to the backbench—the dustbin—of American history.").

[12] *See* Sam Peltzman, *Toward a More General Theory of Regulation*, 19 J.L. & ECON. 211, 211 (1976); George J. Stigler, *The Theory of Economic Regulation*, 2 BELL J. ECON. & MGMT. SCI. 3 (1971); Richard A. Posner, *Natural Monopoly and its Regulation*, 21 STAN. L. REV. 548 (1969); Harold Demsetz, *Why Regulate Utilities?*, 11 J.L. & ECON. 55 (1968).

[13] *See* STEPHEN BREYER, REGULATION AND ITS REFORM 197-239 (1984).

[14] FRIED, *supra* note 3, at 201.

[15] *See* JACOB HACKER, THE ROAD TO NOWHERE 156 (1997) ("In the health policy community, the most influential ideas have been associated with economists. For nearly two decades, the neoclassical critique … has enjoyed a privileged position within health policy circles.").

medicine, the Emergency Medical Treatment and Labor Act resonates with that service duty, as do several antidiscrimination laws with particular significance for health care, mainly Title VI and the Americans with Disabilities Act. But the law of public callings has traditionally involved much more, including the regulation of market entry and of the prices charged for services. This sort of extensive economic regulation was a conspicuous feature of health law in the middle decades of the twentieth century. Yet a narrow conception of the duties owed by businesses affected with a public interest misses the link between such regulation and the law of public callings.

Third, questions about insurance coverage have properly consumed the political and academic discourse. Public debate has thus centered on how, if at all, the state should redistribute resources to guarantee insurance to those who might otherwise go without. Medicare, Medicaid, and the ACA are all primarily responses to that question. The sustained focus on the uninsured has drawn attention away from a persistent, ongoing practice of using state power to curb unfair and oppressive practices in the medical marketplace.

This article aims to recover that neglected tradition of public utility regulation. My claim is not that medicine was once treated as a pure public utility; it was not. My claim, instead, is that laws bearing the characteristic features of public utility regulation became prominent in the decades following the Second World War. Many of those laws remain on the books today. If the American state in the recent past embraced a public utility model for medicine, such an approach would seem to be compatible with our governing institutions and political culture. And the durability of the tradition—the fact that it stretches back more than a century—suggests that the current embrace of market-based approaches in health care is more ephemeral than it may seem. Indeed, as I will explain, the pendulum may already be swinging back toward public utility regulation, notwithstanding the ACA's effort to exploit market forces to drive down costs and improve quality.

Whether treating medicine as a public utility would count as an improvement over a market-oriented approach is a genuinely difficult question. Any effort to closely regulate a large, complex, and rapidly

changing industry would be fraught with difficulties. Economic regulation could create more problems in the medical marketplace than it would solve. But, absent concrete evidence of the ineffectiveness of such regulation, I also see no reason to dismiss the approach out of hand. Most other countries treat health care as a public utility—albeit as a publicly funded, not privately financed, utility. They typically spend far less for care that, along many dimensions, appears superior to ours.[16] And it is not obvious that health-care markets—which suffer from well-understood failings associated with market concentration, informational asymmetries, and moral hazard— would outperform a rate-setting body that, say, used Medicare's payment system as a model.

So I do mean to give the pendulum a gentle push. Commentators seem defensive, almost embarrassed, to raise the possibility of regulating medicine as a utility. Maybe they fear being tarred as insensitive to the risks of public utility regulation, unsophisticated about the market, and ignorant of the American regulatory tradition. They need not be so defensive. Public utility regulation is every bit as much a part of that tradition as laissez faire. And if the market-oriented approaches that are ascendant today prove unsatisfactory, public utility regulation is an option worth exploring. It may not be the answer, but the debate between market-oriented and regulatory approaches should unapologetically examine the virtues and vices of both.

A word about the boundaries of the project. Public utility regulation entails government restrictions on a private business's use of its property. But the state can also adjust business conduct through the use of its purchasing power, and the line between (mandatory) direct regulation

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[16] *See* INSTITUTE OF MEDICINE, U.S. HEALTH IN INT'L PERSPECTIVE: SHORTER LIVES, POORER HEALTH (2013) ("Americans live shorter lives and experience more injuries and illnesses than other people in high-income countries."); ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, HEALTH AT A GLANCE 2013, at 154 (2013) (reporting that per-capita health care spending in the United States is "two-and-a-half times the average of all OECD countries" and "around twice as much" as France and Germany); JOSEPH WHITE, COMPETING SOLUTIONS 278 (1995) ("Within the international standard, costs are controlled by setting fees, making budgets, and imposing controls on investment, not by competition.").

and (voluntary) spending conditions is not always sharp. Medicare, for example, fixes the rate that providers can bill the federal government for providing services to beneficiaries. Because few providers can afford not to participate in Medicare, the program's rate schedules resemble public utility regulation for that population. Yet the economic conditions associated with public insurance programs like Medicare and Medicaid typically apply only to care provided to program beneficiaries. (A few important exceptions are discussed below.[17]) Here, my primary concern is with the economic regulation of the relationships between privately insured patients and the institutions and individuals that care for them.

I. HEALTH CARE: WHERE DO WE GO FROM HERE?

The ACA marks a watershed in its extension of health coverage to tens of millions of the uninsured. By no means, however, has it remedied other flaws in the private health-care system. After the ACA, attention is likely to shift to the challenges that even the insured will face in securing health care in a market plagued by a number of well-understood failings. Should these challenges prove acute, they could feed the perception that private hospitals, physicians, and other providers wield inordinate power in the market—power that federal and state governments may come under pressure to curtail.

1. Supply.

Because those with insurance use more medical services than those without insurance,[18] the existing medical infrastructure could buckle under the weight of increased demand associated with the ACA's insurance expansion. Of greatest immediate concern, policymakers worry about a coming "doc shortage," and especially a shortage of primary-care

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[17] *See infra* Part III.2 (discussing Hill-Burton, the charitable tax exemption, and EMTALA).

[18] *See* Thomas C. Buchmueller et al., *The Effect of Health Insurance on Medical Care Utilization and Implications for Insurance Expansion: A Review of the Literature*, 62 MED. CARE RES. 3, 20 (2005).

physicians, who were in short supply even before the ACA's enactment.[19] Recent estimates suggest that the nation will need at least 40,000 new primary care physicians over the next decade to meet rising demand.[20] Shortages are expected to be especially severe in rural areas and the inner cities.[21]

The nation's shrinking capacity to provide universal primary care has given rise to acute access concerns. One close observer of physician supply, Thomas Bodenheimer, notes that "[i]t can be debated whether the current primary care practitioner-to-population ratio is adequate, but two things are unquestioned: Adult patients are having difficulty gaining timely access to primary care, and a serious shortage of primary care practitioners is inevitable in the near future."[22] Especially in rural and poor urban areas, frustration could mount over the inadequate supply and inappropriate distribution of primary care practitioners.

2. Access.

In an effort to keep their premiums low, most health plans restrict, to some extent or another, the providers they will accept into their coverage networks. Price competition has spurred plans sold on the new insurance exchanges to constrain their provider networks more assertively than in the past.[23] A McKinsey report suggests optimistically that "[t]his trend is

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[19] *See, e.g.*, Elbert S. Huang & Kenneth Finegold, S*even Million Americans Live In Areas Where Demand for Primary Care May Exceed Supply by More than 10 Percent*, 32 HEALTH AFF. 614 (2013); Adam N. Hofer et al., *Expansion of Coverage under the Patient Protection and Affordable Care Act and Primary Care Utilization*, 89 MILBANK QUARTERLY 69 (2011).

[20] *See* Thomas Bodenheimer & Mark D. Smith, *Primary Care: Proposed Solutions to the Physician Shortage Without Training More Physicians*, 32 HEALTH AFF. 1881, 1881 (2013); *but see* INSTITUTE OF MEDICINE, GRADUATE MEDICAL EDUCATION THAT MEETS THE NATION'S HEALTH NEEDS 2-15 (2014) (concluding that fears of a doc shortage may be overblown).

[21] *See* Thomas Bodenheimer & Hoangmai H. Pham, *Primary Care: Current Problems and Proposed Solutions*, 29 HEALTH AFF. 799, 802 (2010).

[22] *Id*. at 801.

[23] *See* David H. Howard, *Adverse Effects of Prohibiting Narrow Network Providers*, 371 NEW ENG. J. MED. 591, 591 (2014) (reporting that, in a recent study, "about

consistent with what we see in most well-functioning consumer markets ranging from cell phone plans to automobiles—a variety of choices comprising different value propositions at different price points."[24]

Not everyone views the trend with such equanimity. In many transactions, as Margaret Radin has emphasized, "[t]here is an irreducibly nonmarket or nonmonetized aspect of human interaction going on between seller and recipient, even though a sale is taking place at the same time."[25] Many people find it hard to square the caregiving relationship at the heart of medicine with the notion that prestigious hospitals and popular physicians might refuse their insurance. The effect even has a name—"doc shock"—and narrow networks have triggered fears that only the wealthy, who can afford to purchase gold-plated plans, will have access to the finest medical care, while everyone else will have to make do with second- and third-rate providers.[26] The concerns are often misplaced—more expensive hospitals typically don't provide higher-quality care[27]—and many people are comfortable with the tradeoffs that come with purchasing cheaper health plans. But many others resent the implication that access to high-quality health care should turn on who pays more.

40% of plan networks were classified as 'ultranarrow' or 'narrow,' meaning that they contracted with less than 30% or 70%, respectively, of the hospitals in the plan rating area").

[24] McKinsey Center for U.S. Health System Reform, *Hospital Networks: Configurations on the Exchanges and their Impact on Premiums* (2013), at www.mckinsey.com/~/media/mckinsey/dotcom/client_service/Healthcare%20Systems%20and%20Services/PDFs/Hospital_Networks_Configurations_on_the_Exchanges_and_Their_Impact_on_Premiums.ashx.

[25] MARGARET JANE RADIN, CONTESTED COMMODITIES 107 (1996).

[26] *See* Lori Gottlieb, *Daring to Complain about Obamacare*, N.Y. TIMES, Nov. 10, 2013 (describing frustration at being "mandated to buy expensive exchange or private policies without access to their current doctors").

[27] *See* Chapin White et al., *Understanding Differences Between High- And Low-Price Hospitals: Implications for Efforts to Rein in Costs*, 33 HEALTH AFF. 324, 329 (2014).

3. Discriminatory prices.

Over the past two years, a number of widely circulated articles have exposed enormous and hard-to-justify price variations in the health-care system.[28] Story after story has highlighted what health-policy experts have long understood: that the uninsured pay higher prices for medical services than the insured; that prices for medical services vary dramatically from hospital to hospital, even in the same geographic region; and that the prices charged bear no apparent relationship to underlying costs. Responding to interest in the issue, Medicare in 2013—for the first time—released data documenting extraordinary variations in the costs that hospitals claimed they incurred for treating a range of conditions.[29] Encouraged by the positive response, Medicare followed up in 2014 with the public release of comprehensive billing data for each of its 880,000 participating physicians.[30]

Because discriminatory pricing is most apparent in the prices that hospitals charge the uninsured, concerns about variable prices may become less urgent as the ranks of the uninsured dwindle. The ACA, however, leaves intact a different source of "unfair" price variation: variations in prices for exchange plans that can't be explained with reference to variable demand for medical services. The premiums for exchange plans in Wisconsin are substantially higher—sometimes twice as high—as premiums in neighboring Minnesota.[31] And where a standard "silver" plan for a family of four in Nashville, Tennessee cost $6,708 in 2014, the same plan in Jackson, Mississippi—one state over—ran

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[28] For two of the most prominent exposés, see Steven Brill, *Why Medical Bills Are Killing Us*, TIME, Apr. 4, 2013; Elisabeth Rosenthal, *As Hospital Prices Soar, a Stitch Tops $500*, N.Y. TIMES, Dec. 3, 2013.

[29] *See* Medicare Provider Utilization and Payment Data, at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/index.html.

[30] *See* Jonathan Blum, *Next Steps in Data Transparency*, THE CMS BLOG, Apr. 2, 2014, at http://downloads.cms.gov/files/Madara_Final_Signed.pdf.

[31] *See* Christopher Snowbeck & MaryJo Webster, *On health exchanges, rates swing at Minnesota border*, PIONEER PRESS, Nov. 2, 1013 (examining unpublished data from the Kaiser Family Foundation).

$14,592.[32] Because silver plans are designed to cover only 70%of a family's average health-care expenses, the average Jackson family will spend an additional $4,377 out of pocket, more than twice as much as an average Nashville family. These disparities, which appear to be driven primarily by differences in provider power, have already begun to stoke claims of unfairness arising from the happenstance of geography.[33]

4. Costs.

All of these concerns—with supply, access, and discriminatory pricing—are likely to pale in comparison to the frustration that could attend the continued escalation of prices for medical care. In rejecting a single-payer model for paying for medical services, the ACA pinned front-line responsibility for controlling private medical spending on private health plans. The exchanges are a key feature of this strategy. By facilitating cost-conscious shopping in the individual and small-group markets, the exchanges sharpen health plans' incentives to negotiate low prices with providers and to encourage them to practice efficiently.

The success of what has become known as "managed competition" depends for its success on the ability of managed care organizations—whether operating as insurers or as third-party administrators for employers—to change how providers practice medicine.[34] Although managed care organizations have been at the center of health policy for the past quarter-century, their track record is not encouraging. The rise of managed care in the 1990s appeared to reduce cost growth for a brief period, but medical inflation resumed its inexorable rate of increase by

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[32] *See* ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, HEALTH INSURANCE MARKETPLACE PREMIUMS FOR 2014, available at http://www.whitehouse.gov/sites/default/files/docs/marketplace_premiums_ib_final.pdf.

[33] *See, e.g.*, Jordan Rau, *In Southwest Georgia, the Affordable Care Act Is Having Trouble Living Up to its Name*, KAISER HEALTH NEWS, Feb. 3, 2014.

[34] *See* Alain C. Enthoven, *Consumer-Choice Health Plan*, 298 NEW ENG. J. MED. 650 (1978) (laying out the principles of managed competition).

the early 2000s.[35] Cost growth in the private market has generally outpaced cost growth in Medicare, and that divergence has accelerated over the past decade.[36]

Managed care organizations face a number of challenges when it comes to restraining medical spending. Direct oversight of provider behavior is devilishly hard.[37] Financial incentives are blunt tools to encourage hospitals and physicians to provide low-cost, high-quality care.[38] And public resistance to cost-management techniques—especially utilization review, but also narrow networks and gatekeeping requirements—can be fierce.[39]

Of greatest significance, dominant providers' market power can enable abusive pricing practices and impede insurers' efforts to drive down costs.[40] In markets where managed care organizations cannot credibly threaten to exclude high-cost providers from their coverage networks—if, for example, exclusion of a prominent local hospital would make a plan unmarketable—these providers can name their price. Provider concentration can thus thwart efforts to restrain prices.

Concentration in the health-care sector is pervasive. Deploying a widely used economic metric, David Cutler and Fiona Scott Morton

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[35] *See* CMS Research Statistics, Table 13, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/tables.pdf.

[36] *See* Cristina Boccuti & Marilyn Moon, *Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades*, 22 HEALTH AFF. 230, 232-33 (2003); KAISER FAMILY FOUNDATION, PER ENROLLEE GROWTH IN MEDICARE SPENDING AND PRIVATE HEALTH INSURANCE PREMIUMS (FOR COMMON BENEFITS), 1970-2012, at http://kff.org/health-costs/slide/per-enrollee-growth-in-medicare-spending-and-private-health-insurance-premiums-for-common-benefits-1970-2012/.

[37] *See* James C. Robinson, *The End of Managed Care*, 285 J. AM. MED. ASS'N 2622, 2627 (2001).

[38] *See* Einer Elhauge, *Why We Should Care about Health Care Fragmentation*, in THE FRAGMENTATION OF U.S. HEALTH CARE 7 (Einer Elhauge, ed. 2010).

[39] *See* Robinson, *supra* note 38, at 2623.

[40] *See* Gerard F. Anderson et al., *It's the Prices, Stupid*, 22 HEALTH AFF. 89 (2003); David M. Cutler & Fiona Scott Morton, *Hospitals, Market Share, and Consolidation*, 310 J. AM. MED. ASS'N 1964, 1969 (2013).

recently showed that roughly half of all hospital markets are highly concentrated and another third are moderately concentrated.[41] The extent of concentration has increased sharply since the 1980s, and the trend is accelerating.[42] More and more hospitals are transforming themselves into integrated medical systems with close links to physician practices.[43] In one of the more startling changes over the past decade, hospitals have been purchasing physician practices at a furious clip.[44] By 2011, for the first time, more than half of all physician practices were owned by hospitals.[45]

The ACA may be partly responsible. One of the notorious failings of the American health-care system is its fragmentation—the inability of disparate physicians, hospitals, and other providers to coordinate the care they offer to patients, especially the chronically ill.[46] To address this challenge, the ACA uses Medicare reform to spur the development of integrated medical systems.[47] Most prominently, the ACA encourages the creation of accountable care organizations (ACOs), which can share in any savings they generate for Medicare if they hit certain quality targets and reduce spending for a target population.[48]

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[41] *See* Cutler & Morton, *supra* note 41, at 1966.

[42] *See id.*; Julie Creswell & Reed Abelson, *New Laws and Rising Costs Create a Surge of Supersizing Hospitals*, N.Y. TIMES, Aug. 12, 2013.

[43] *See* Lawton Robert Burns & Ralph W. Muller, *Hospital-Physician Collaboration: Landscape of Economic Integration and Impact on Clinical Integration*, 86 MILBANK Q. 375 (2008).

[44] *See* Manoi Jain, *Doctors in Private Practice Are Now Joining Hospitals Staffs*, WASH. POST, Mar. 12, 2012.

[45] *See* Cutler & Morton, *supra* note 41, at 1966 ("From 2004 to 2011, hospital ownership of physician practices increased from 24% of practices to 49%.").

[46] *See generally* THE FRAGMENTATION OF U.S. HEALTH CARE (Einer Elhauge, ed. 2010).

[47] *See* Nicholas Bagley, *Bedside Bureaucrats: Why Medicare Reforms Hasn't Worked*, 101 GEO. L.J. 519, 569 (2013).

[48] *See* ACA, sec. 3022, § 1899. For a more comprehensive list ACA's various efforts to promote greater coordination, see Katherine Baicker & Helen Levy, *Coordination versus Competition in Health Care Reform*, 369 NEW ENG. J. MED. 789, 790 (2013).

Laudable as that effort is, it is at loggerheads with the ACA's attempt to use managed care to reduce medical inflation. As Katherine Baicker and Helen Levy have noted, attempts to defragment the health-care sector to improve care coordination can contribute to anticompetitive consolidation.[49] Recent empirical work confirms the point.[50] Although the antitrust agencies have issued policies that aim to discourage such consolidation,[51] few expect antitrust enforcement to much diminish provider concentration.[52] Success on the coordination front may therefore compromise managed care's ability to reduce health-care expenditures.[53]

As a result, dominant hospital systems in some markets may come to resemble the natural monopolies that have traditionally been regulated as public utilities. Should those systems exploit their market power, escalating insurance premiums would cut into wages and could raise the cost of exchange plans to unaffordable levels. Tax credits for exchange plans will provide only partial relief. Through 2018, the tax credits will rise to cover any increase in exchange premiums. After that, however, the credits will grow only at the rate of inflation, shifting the costs of growing premiums to individuals and families.[54]

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[49] *See id*. at 789.

[50] *See, e.g.*, Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation—Update*, THE SYNTHESIS PROJECT (June 2012); Austin Frakt et al., *Plan-Provider Integration, Premiums, and Quality in the Medicare Advantage Market*, 6 HEALTH SERVS. RES. 1996 (2013); Laurence C. Baker et al., *Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending*, 33 HEALTH AFF. 756 (2014).

[51] *See* 76 Fed. Reg. 67026 (2011).

[52] *See* Clark C. Havighurst & Barack D. Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847, 868-76 (2011) (discussing the failure of antitrust enforcement to prevent consolidation in the health-care sector and raising concerns about ACOs).

[53] *But see* Thomas C. Tsai & Ashish K. Jha, *Hospital Consolidation, Competition, and Quality: Is Bigger Necessarily Better?*, 312 J. AM. MED. ASS'N 29 (2014) (noting that "consolidation is not integration" and arguing that smaller hospital systems might be well-equipped to provide high-quality care).

[54] *See* I.R.C. §36B(b)(3)(A)(ii); *see also* JOHN E. MCDONOUGH, INSIDE NATIONAL HEALTH REFORM 301 (2011) (noting that premiums could increase as much as 10% per year).

The meteoric growth of high-deductible health plans could exacerbate cost concerns. In 2006, just one out of ten employees received employer-sponsored coverage with a deductible that exceeded $1,000 per year. (That's for individual coverage; deductibles for family coverage are higher.) By 2013—just seven years later—almost four in ten did.[55] At small firms today, one in three employees has a deductible in excess of $2,000 per year.[56] Many exchange plans will have similarly high deductibles.[57] Caps on out-of-pocket expenses—set at $6,350 for individuals and $12,700 for families—will somewhat limit financial exposure,[58] but many people are already experiencing sticker shock at the medical bills that insurance doesn't cover.[59]

The proliferation of high-deductible plans means that millions of insured families and individuals could, when they encounter health problems, find themselves in a precarious financial situation.[60] Although the ACA will allow many families to avoid bankruptcy, it by no means fully protects them against the financial shocks associated with health care.

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The problems sketched out here—supply shortages, access restrictions, and capricious, exorbitant prices—are specific manifestations of deep problems in the health-care market. Prices for health care are

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[55] *See* KAISER FAMILY FOUNDATION, EMPLOYER HEALTH BENEFITS, 2013 ANNUAL SURVEY 110 (2013).

[56] *See id* at 111.

[57] *See* Leslie Scism & Timothy W. Martin, *High Deductibles Fuel Worries of Health-Law Sticker Shock*, WALL ST. J., Dec. 8, 2013.

[58] *See* Robert Pear, *A Limit on Consumer Costs Is Delayed in Health Care Law*, N.Y. TIMES, Aug. 12, 2013.

[59] *See* Peter Frost, *Obamacare Deductibles a Dose of Sticker Shock*, CHI. TRIB., Oct. 13, 2013.

[60] *Cf.* MCDONOUGH, *supra* note 55, at 300 ("The Massachusetts experience with a similar structure shows that most consumers choose lower-premium options, leaving them vulnerable to high cost sharing the event of a serious illness.").

rarely discussed openly and comparison shopping is almost unheard of.[61] Informational asymmetries make consumers unusually dependent on third parties—mainly physicians—in making health-care decisions.[62] Scientific evidence about the medical benefits of conventional therapies is often so spare that it's hard to make good cost-quality tradeoffs.[63] Physicians and hospitals can stimulate demand for their own services (ordering tests, suggesting surgery) and often have financial incentives to do so.[64] And the prevalence of insurance enables excessive consumption because patients are shielded from the full costs of care.[65]

None of this proves that a market-based approach to the distribution of health-care resources is bad policy. Such an approach could still be the least-worst option among a set of unpalatable choices.[66] Nonetheless, persistent problems with supply, access, and prices could stoke dissatisfaction with a market-based approach to organizing the private health-care sector. It's impossible to predict the depth of such dissatisfaction; indeed, the ACA could provoke systemic changes that mitigate much of it. If not, however, pressure will build for a government response.

What might such a response look like? Some critics on the right hope to jettison the ACA and its effort to achieve near-universal coverage in

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[61] *See* Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 653-59 (2008).

[62] *See* Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).

[63] *See* U.S. CONGRESS, OFFICE OF TECH. ASSESSMENT, OTA-H-608, IDENTIFYING HEALTH TECHNOLOGIES THAT WORK: SEARCHING FOR EVIDENCE 21 (1994) (estimating that at least eighty percent of widely used medical interventions lack rigorous research documenting their efficacy).

[64] *See* HENRY J. AARON, SERIOUS AND UNSTABLE CONDITION 13-17 (1991).

[65] *See id*. at 10-13.

[66] *See* Gary S. Becker, *Competition and Democracy*, 1 J. L. ECON. 105, 109 (1958) ("[D]oes the existence of market imperfections justify government intervention? The answer would be 'no,' if the imperfections in government behavior were greater than those in the market.").

favor of a purer embrace of the market.[67] As they see it, the health-care market's failings have been exacerbated by a slew of well-intentioned but poorly designed state interventions. For them, the ACA is the apotheosis of this sort of needless government meddling, its nominal embrace of managed competition belied by regulatory restrictions that will impede the very competition the ACA was supposed to enable. Only by ditching the ACA—and sweeping off the books other needless laws—can the promise of the market be realized. Strictly as a matter of practical politics, however, the ACA's abandonment looks increasingly unlikely. Millions of people have already signed up for exchange plans; millions more are now enrolled in Medicaid. Returning to a pre-ACA status quo in which they would lose that coverage, and insurers would lose their business, is close to a political non-starter.[68] To be sure, the ACA could be adjusted in a more market-friendly direction by relaxing certain regulations that limit the range of plans that can legally be sold.[69] But the ACA's core is likely to remain intact, and fiddling on the margins isn't especially likely to resolve the market failings that might spur interest in alternatives to managed competition.

From the political left, the leading reform alternative is the adoption of a single-payer scheme—Medicare for All. But moving to single-payer is, if anything, even less likely than the abandonment of the ACA. Many of those with employer-sponsored coverage—almost 150 million people—would resist surrendering it in favor of a government-run plan.[70]

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[67] *See, e.g.*, Richard A. Epstein & David A. Hyman, *Fixing Obamacare: The Virtues of Choice, Competition, and Deregulation*, 68 ANN. SURVEY AM. LAW 493 (2013).

[68] *See* Henry J. Aaron, *Here to Stay – Beyond the Rough Launch of the ACA*, 370 NEW ENG. J. MED. 2257 (2014) ("Although some opponents continue to call for repeal of the ACA, the law is here to stay."). *But see* David Super, *The Modernization of American Public Law: Health Care Reform and Popular Constitutionalism*, 66 STAN. L. REV. 873, 897-901 (2014) (arguing that the ACA is more vulnerable than its supporters appreciate).

[69] *See* Joseph R. Antos, *Health Care Reform after the ACA*, 370 NEW ENG. J. MED. 2259, 2261 (2014).

[70] *See* KAISER FAMILY FOUNDATION, HEALTH INSURANCE COVERAGE OF THE TOTAL POPULATION, at http://kff.org/other/state-indicator/total-population/; HACKER, *supra* note 15, at 148 (reporting that public "[s]upport for the [Clinton

And insurers (including the exchange insurers) are a well-financed, well-organized interest group that would lobby fiercely against any move that would put them out of business.[71]

Public utility regulation offers a less disruptive alternative, one that retains the basic architecture of the private financing system while asserting state control over the medical industry's perceived excesses.[72] That such regulation would obviate the need for socialized insurance is no coincidence: public utility regulation has long been understood to preserve a role for the private while attending to the needs of the public.[73] As Bruce Wyman explained, "[t]his principle of State control does not lead one to socialism; indeed, it saves one from socialism if truly understood."[74] Here, Wyman was echoing Henry Carter Adams's claim a generation earlier that economic regulation "stands opposed to anarchy on the one hand, which is individualism gone to seed; and to socialism on the other, which, both historically and logically, is a revolt against the superficial claims and pernicious consequences of *laissez-faire*."[75]

II. THE AMERICAN TRADITION OF PUBLIC UTILITY REGULATION

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health-care] proposal waned … because of a general fear among Americans that the proposal would make them worse off").

[71] *Cf.* MCDONOUGH, *supra* note 55, at 47 ("Single-payer advocates, passionately as they believed in their case, were unable to convince even sympathetic lawmakers that there was a way to get a Medicare for All bill to the president's desk."); HACKER, *supra* note 15, at 177 ("[I]t is extremely unlikely that [a single-payer] plan would have garnered strong enough support to overcome the frenetic opposition it would have provoked.").

[72] *Cf.* M. Gregg Bloche, *The Emergent Logic of Health Law*, 82 S. CAL. L. REV. 389, 397 (2009) (arguing that reformers "should look for potential evolutionary pathways that launch from present-day institutional arrangements and incentives").

[73] *See* FRIED, *supra* note 3, at 164 ("Indeed, progressive commentators routinely suggested, regulation might be the best friend capitalism had, given that public regulation of private property was the only remaining viable alternative to outright public ownership.").

[74] WYMAN, *supra* note 5, at vii.

[75] Henry Carter Adams, *Relation of the State to Industrial Action*, in RELATION OF THE STATE TO INDUSTRIAL ACTION AND ECONOMICS AND JURISPRUDENCE 125 (Joseph Dorfman, ed. 1954).

The modern reluctance to entertain the possibility of regulating medicine as a public utility doesn't arise from clear evidence that it can't work. International experience suggests that it can.[76] It seems to stem, instead, from the persistent sense that, in the United States, public utility regulation is adopted rarely and only as a last resort. Apart from occasional and regrettable excesses, typified by the regulation of the airline and trucking industries, public utility regulation (the story goes) has properly been confined to the regulation of natural monopolies. Because medicine—a fragmented industry comprising hospitals, physicians, and a dizzying array of other providers—is not a true natural monopoly, treating it as a public utility is out of step with historical practice and presumptively inappropriate. Maybe other countries treat medicine as a utility, but it's not how we do things here.

But in fact we do. The dominant account reflects a certain historical blindness about the pivotal role that public utility regulation has played in the American state. In the decades following the Civil War, the economic regulation of public callings became both common and intrusive. By the Progressive Era, such regulation covered an extraordinary array of industries—not just natural monopolies. What linked those industries together, and what made state intervention both necessary and consistent with the Fourteenth Amendment, was the perception that they wielded undue market power over goods or services upon which the public had grown dependent.

The dominant account also overlooks how extensively public utility regulation has shaped health law. As medicine became technologically more sophisticated and acquired substantial market power in the deacdes after the Second World War, policymakers began drawing in earnest on the public utility model. Their embrace of that model is unsurprising: public utility regulation was developed precisely to address the concerns with supply, access, discrimination, and unfair pricing that plague the modern medical industry.

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[76] *See* WHITE, *supra* note 17, at 7 (noting that other industrialized nations control "through systems of regulation" that include "fee schedules or budgeting—usually both" and "limits on capital investment for the largest part of hospital care").

1. The Rise of Public Utility Regulation.

During the Gilded Age, the rapid advance of the railroads, the rise of industrial production, and improvements in international trade fueled explosive growth.[77] These developments also stirred resentment, at first from farmers who, subject to the fluctuations of the international markets and the caprice of the railroad magnates, felt caught in a vise.[78] In the 1870s, agrarian interests in the Midwest pressed for the adoption of what became known as the Granger laws, which fixed prices for the railroads and grain warehouses upon which farmers depended to market their goods.

But were the new laws constitutional? The ratification of the Fourteenth Amendment, together with the growing prominence of laissez faire ideas in economic and legal thought, had raised anew the question of how far, and under what circumstances, states could intrude on the rights to private property and liberty of contract.[79] Even the most committed adherents to laissez faire recognized that the due process clause posed no general impediment to the regulation, through the police power, of public health, safety, and morals.[80] Less clear was whether the due process clause constrained states' ability to oversee the fairness of private business transactions. As Ernst Freund explained in 1914, economic interests "obviously do not affect the public welfare as urgently as safety, morals and order. With regard to many conceivable phases of industrial regulation, the legitimacy of the police power is seriously disputed."[81]

The Granger laws came before the Supreme Court in 1877. In *Munn v. Illinois* and its companion cases, the Court seemed to accept the principle

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[77] *See* ROBERT H. WIEBE, THE SEARCH FOR ORDER 1877-1920, at 46 (1967).

[78] *See* RICHARD HOFSTADTER, THE AGE OF REFORM 51-52 (1955).

[79] *See, e.g.*, Thomas M. Cooley, *Limits to State Control of Private Business*, 1 PRINCETON REV. 233 (1878) (considering the question).

[80] *See* FRIED, *supra* note 3, at 20.

[81] Ernst Freund, *Police Power*, in CYCLOPEDIA OF AMERICAN GOVERNMENT, VOL. 2, 706, 707-08 (1914).

that the states lacked plenary power to regulate the affairs of purely private businesses.[82] But the Court rejected the claim that all private businesses necessarily had a constitutional right to conduct their business relations as they saw fit. The Court reasoned that some businesses were "affected with a public interest" and, as such, were the appropriate targets of economic regulation.[83]

As refashioned by the Supreme Court, the concept of businesses "affected with a public interest" had a source in two bodies of law. The first was the common law, which from time immemorial had imposed special duties on certain callings—most notably, innkeepers and common carriers.[84] (Interestingly, ancient English common law appears to have treated the practice of medicine as a public calling.[85]) Those duties included, among other things, accepting all comers on a nondiscriminatory basis and offering reasonable rates.[86]

Corporate charters provided the second source for the idea that some businesses owed special duties to the public. Before the Civil War, corporations by and large were individually chartered under state (and sometimes federal) law.[87] Those business-specific charters often included detailed conditions on the businesses receiving them.[88] Although the gradual shift to general charters of incorporation eventually did away

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[82] *See* 94 U.S. 113, 126 (1877).

[83] *Id.*

[84] *See, e.g.*, JOSEPH HENRY BEALE, THE LAW OF INNKEEPERS AND HOTELS (1906).

[85] *See* WYMAN, *supra* note 5, at 7 ("From other cases it is plain that the curing of man or beast was considered a public calling.").

[86] *Cf. id.* at 16 ("To compel the proprietors of those businesses which had been regarded as peculiarly affected with a public interest to serve all that applied at reasonable rates was immemorial practice and therefore was indisputably due process of law.").

[87] *See* WILLARD HURST, THE LEGITIMACY OF THE BUSINESS CORPORATION IN THE UNITED STATES 13-18 (1970).

[88] *See* Cooley, *supra* note 80, at 233 ("Wherever the business is a privilege, and the taking out of a license is required, the state may impose conditions on the privilege."); ERNST FREUND, THE POLICE POWER 19 (1904) (similar).

with business-specific charter conditions,[89] the idea persisted that the state could properly oversee the conduct of private corporations carrying out public business.

Munn's apparent endorsement of the principle that the Constitution prohibited the economic regulation of a purely private business has led many to read it as a step on the road to *Lochner*.[90] As William Novak has recently shown, however, the opposite is closer to the truth: *Munn* inaugurated an era of vigorous economic regulation of private businesses deemed to be affected with a public interest.[91] The public utility idea was expansive, not restrictive, and the agrarian populists who succeeded the Grange agitated, with some success, for legislation aimed at the "money power."[92] In particular, the regulation of railroads and grain elevators became ubiquitous, first at the state level[93] and then, with the 1887 enactment of the Interstate Commerce Act, at the federal level as well.[94] More generally, the populists' distrust of private power found expression in the common law. By 1900, the industries that the courts deemed to be "affected with a public interest" included banking, insurance, railroads, telephone, telegraph, electric power, natural gas, water, urban transportation, heating, inter-urban electric, motor bus and truck, airways, radio, pipe lines, warehouses, stockyards, ice plants, milk, fuel, and meat-packing.[95]

Even as the populist movement sputtered out in the mid-1890s, a new generation of progressive reformers came to the fore. Centered in the cities, supported by the rising middle class, and optimistic about expert

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[89] NOVAK, *supra* note 3, at 106.

[90] *See* Novak, *supra* note 3, at __ (collecting sources).

[91] *See id*.

[92] *See generally* GEORGE H. MILLER, RAILROADS AND THE GRANGER LAWS (1971).

[93] *See* Novak, *supra* note 3, at __.

[94] Interstate Commerce Act of 1887, 24 Stat. 379.

[95] *See* Charles K. Burdick, *The Origin of the Peculiar Duties of Public Service Companies*, 11 COLUM. L. REV. 514, 515 (1911) (cataloging public service corporations); WYMAN, *supra* note 5 (1904) (same); FREUND, *supra* note 89, at 381 (same).

governance, the progressives shared with the populists an intense distrust of private power.[96] Yet, as historian Robert Wiebe explains, "[w]here their predecessors would have destroyed many of urban-industrial America's outstanding characteristics, the new reformers wanted to adapt an existing order to their own ends."[97]

In the early decades of the twentieth century, the progressives called for the creation of regulatory bodies that could better control public utilities.[98] "The human interests and legal rights protected remain the same," John Dickinson explained, "but the old legal procedure has been superseded by direct governmental action on the plea of prevention, or greater speed and effectiveness of the remedy."[99] Starting with Wisconsin and New York in 1907, the states moved almost without exception to establish public service commissions.[100] The new commissions oversaw a vast range of industries, including

> steam railroads, electric and street railways, interurban or suburban railways, elevated railroads or subways, automobile railroads, steamboats and other water craft, express lines and messenger lines, signaling facilities, bridges and ferries connected with railroads, pipe lines for the transportation of oil or water, sleeping, parlor and drawing-room cars, terminals, union depots, docks, wharves, storage elevators, fast freight lines, stage lines, messenger companies, telegraph and telephone companies, facilities for the manufacture and sale of gas or electricity, heat,

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[96] *See* HOFSTADTER, *supra* note 79, at 313 (arguing that progressive regulation reflected "the purpose of eliminating that private power to tax which is the prerogative of monopoly").

[97] WIEBE, *supra* note 78, at 165.

[98] *See* G. LLOYD WILSON ET AL., PUBLIC UTILITY REGULATION, at 13 (1938).

[99] JOHN DICKINSON, ADMINISTRATIVE JUSTICE AND THE SUPREMACY OF LAW 7 (1927); *see also* WIEBE, *supra* note 78, at 176 ("The heart of progressivism was the ambition of the new middle class to fulfill its destiny through bureaucratic means.").

[100] *See* FRIED, *supra* note 3, at 161.

light, water, power, hot or cold air or steam, and irrigation and sewage facilities.[101]

By 1916, Frank Goodnow, one of the fathers of American administrative law, could note the significance of the "change of ideas" when it came to the regulation of public utilities: "Not only is no constitutional question any more raised as to the power of the competent organ of our government to take the necessary regulatory measures but public opinion justifies regulation of so drastic a character that it would hardly have been deemed possible even a quarter of a century ago."[102]

2. The Attributes of Public Callings.

What made a business a public calling? Or, to put it another way, when was it appropriate for the state to subject an industry to public utility regulation? Because constitutional objections to such regulation dropped away only when the business was deemed "affected with a public interest," judicial doctrine played an unusually prominent role in shaping the policy debate.[103] Not that the courts were very clear about the

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[101] I. Leo Sharfman, *Commission Regulation of Public Utilities: A Survey of Legislation*, 53 ANNALS OF THE AM. ACAD. OF POL. & SOC. SCI. 1, 8 (1914); *see also* GUSTAVUS H. ROBINSON, CASES AND AUTHORITIES ON PUBLIC UTILITIES 78 (2d ed. 1935) (offering a similarly expansive list).

[102] FRANK JOHNSON GOODNOW, THE AMERICAN CONCEPTION OF LIBERTY AND GOVERNMENT 28-29 (1916); FELIX FRANKFURTER, THE PUBLIC AND ITS GOVERNMENT 31 (1930) ("Suffice it to say that through [modern government's] regulation of those tremendous human and financial interests which we call public utilities, the government may in large measure determine the whole socio-economic direction of the future."); *see also* Dexter Merriam Keezer, *Some Questions Involved in the Application of the "Public Interest" Doctrine*, 25 MICH. L. REV. 596, 596 (1927) ("[A]pplication of the ['affected with a public interest'] doctrine has been steadily expanded, bringing within its scope an increasing range and diversity of enterprises … [that] will continue to be enlarged.").

[103] *See* ROBINSON, *supra* note 102, at 5 ("[T]he legislature speaks and the court also speaks, and because the selection [of public businesses] is conceived of as a matter of 'due process of law' … the apparatus [for selecting] is a combination of legislature-court-state-and-federal elements.").

attributes of public callings.[104] As Frankfurter and Henry Hart noted, "the futile efforts at dogmatic statement of doctrine cover a clash of opinion on a far reaching issue; namely, to what degree free competition is so complete a protection to the public interest as to render arbitrary any governmental departure from it."[105]

Nonetheless, legislatures and courts had, by the early decades of the twentieth century, reached a workable consensus about which businesses were affected with a public interest.[106] That consensus was oriented around two basic considerations: first, that the business in question met an important human need; and second, that some feature of the relevant market presented the risk of oppression.[107] Where these conditions were satisfied, it was both appropriate as a policy matter and fully

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[104] *See* FRIED, *supra* note 3, at 169 (discussing the "dizzying array of tests to determine whether a business was affected with a public interest"); FREUND, *supra* note 89, at 382.

[105] *See* Felix Frankfurter & Henry M. Hart, Jr., *Rate Regulation*, in THE ENCYCLOPEDIA OF THE SOCIAL SCIENCES 106 (1934). Indeed, not everyone was convinced that the Fourteenth Amendment had anything to say about the constitutionality of the economic regulation of private business. *See* Edward A. Adler, *Business Jurisprudence*, 28 HARV. L. REV. 135, 158 (1914); Burdick, *supra* note 96, at 516.

[106] *See* BARRY CUSHMAN, RETHINKING THE NEW DEAL COURT 50 (1998) ("Marginal disagreements concerning the precise location of the boundary between public and private enterprise persisted. There was, however, a broad measure of agreement concerning where the division lay … .").

[107] *See* Wolff Packing Co. v. Court of Industrial Relations, 262 U.S. 522, 538 (1923) ("In nearly all the businesses [that are affected with a public interest] the thing which gave the public interest was the indispensable nature of the service and the exorbitant charges and arbitrary control to which the public might be subjected without regulation."); Block v. Hirsh, 256 U.S. 135, 156 (1921) ("The space in Washington is necessarily monopolized in comparatively few hands, and letting portions of it is as much a business as any other. Housing is a necessary of life. All the elements of a public interest justifying some degree of public control are present."); REXFORD TUGWELL, THE ECONOMIC BASIS OF PUBLIC INTEREST 100 (1922) ("[T]he courts will permit the regulation of the prices and standards of service of a business under the economic interest phase of the police power when: 1. The commodity or service is virtually a necessity. 2. There is maintained a price or a standard of service resulting in harm to consumers.").

constitutional to require the industry to satisfy the public need on a reasonable and nondiscriminatory basis.

a. Necessity.

Throughout the Progressive Era, it was common ground that a business was "affected with a public interest" only if it controlled access to a necessity. As Wyman explained in 1911:

> The extraordinary activity of the law in behalf of the individual is … confined to necessary services. The law has little concern with the monopolization of unessential things. It subjects a "scenic railway" at an amusement park to no exceptional liabilities. It leaves a circular railway built primarily to view the Niagara Gorge outside the pale of State aid. And it leaves skating rinks and theaters to deal as they please with their public, and exclude whomsoever they choose.[108]

Still, necessity was a broad concept. It was linked not to bare survival, but to ideas of dependence, expectation, and reliance. In 1926, the influential progressive economist John Maurice Clark explained that "[w]hat we think of as economic coercion acts mainly through the power to withhold access to goods or services, where the person from whom they are withheld needs access to these particular goods or services so much that he is, or feels, 'dependent' on them to a substantial degree."[109] Pushing the point even further, Rexford Tugwell—a future member of

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[108] WYMAN, *supra* note 5, at 99; *see also* Tyson v. Banton, 273 U.S. 418, 440 (1927) (rejecting an effort to regulate the price of admission to the theater in part because "in importance it falls below … an interest in … food and shelter"); Wolff Packing Co., 262 U.S. at 537 ("It has never been supposed, since the adoption of the Constitution, that the business of the butcher, or the baker, or the tailor, the wood chopper, the mining operator or the miner was clothed with such a public interest that the price of his product or his wages could be fixed by state regulation."); A.M. Holter Hardware Co. v. Boyle, 263 F. 134, 137 (D. Mont. 1920) (invalidating price regulation that "ranges from the street corner vendor of popcorn and bananas to the merchant prince, from coal to diamonds, from the babe's first swaddling band and cradle to the aged man's shroud, his coffin, and his grave. Trifles, necessities, luxuries— all are within its scope.").

[109] *See also* JOHN MAURICE CLARK, SOCIAL CONTROL OF BUSINESS 115 (2d ed. 1939).

President Roosevelt's Brain Trust—canvassed the case law in 1922 and concluded that, "[p]erhaps . . . the most precise and complete definition would be one which would conceive a necessity as any good or service which contributes to a psychologically full life."[110]

Something might be thought "necessary" not just for individuals, but for society more broadly. The Supreme Court captured the thought in *New State Ice Co. v. Liebmann*, when it rejected an effort to regulate the sale of ice because it was not "a paramount industry, upon which the prosperity of the entire state in large measure depends."[111] Frankfurter similarly emphasized that "[o]ur whole social structure presupposes satisfactions for which we are dependent upon private economic enterprise."[112] Linking necessity to the economic and social development of the broader community helps explain why banking and insurance, among other industries, were thought to be affected with a public interest.[113] As Freund explained, "banks and life insurance companies are the depositaries of a large proportion of the savings of the people, so that the management of each institution affects a considerable part of the public."[114]

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[110] TUGWELL, *supra* note 109, at 102.

[111] 285 U.S. 262, 277-78 (1932).

[112] FRANKFURTER, *supra* note 104, at 81; *see also* LYON ABRAMSON ET AL., GOVERNMENT AND ECONOMIC LIFE, VOL. II 622 (1940) (observing that an individual's need for public utilities "is augmented by his indirect interest in living in a society where these services are readily available for general social and industrial use"); Gustavus Robinson, *The Public Utility Concept in American Law*, 41 HARV. L. REV. 277, 303 (1928) (noting that the concept of a public utility responded to "the sense, upon the part of contemporary society, of its dependence upon certain sorts of enterprises").

[113] *See* German Alliance Ins. Co. v. Lewis, 233 U.S. 389, 414-15 (1914) (insurance); Noble State Bank v. Haskell, 219 U.S. 104, 111-13 (1911) (banking).

[114] FREUND, *supra* note 89, at 419.

b. Power.

A business was not "affected with a public interest" merely because the public was dependent on the goods or services that it controlled.[115] In Wyman's telling, the law of public callings served to protect against a business's exploitation of its monopoly power.[116] In this, the law of public callings bore a kinship to antitrust law: the latter aimed to prevent monopoly, the former to control it. The idea that state power to regulate the economic affairs of private business turned on the presence of monopolistic conditions found expression in Supreme Court opinions throughout the period.[117]

Yet a business need not be monopolistic in a strict sense. An extraordinary range of market features—the costs of shopping around, bargaining inequalities, informational disadvantage, rampant fraud, collusive pricing, emergency conditions, and more—could all frustrate competition and so give rise to "virtual" or "practical" monopolies that would warrant state intervention.[118] By no means was the regulation of public callings confined to the natural monopolies that, today, are thought to be its proper targets.[119] The 1914 case of *German Alliance Insurance Company v. Lewis* illustrates the point. As the Supreme Court

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[115] Wolff Packing Co. v. Court of Industrial Relations, 262 U.S. 522 (1923); *see also* Freund, *supra* note 82, at 111.

[116] Bruce Wyman, *The Law of Public Callings as a Solution to the Trust Problem*, 17 HARV. L. REV. 156 (1903).

[117] *See, e.g.*, Wolff Packing Co., 262 U.S. at 538; German Alliance Ins. Co., 233 U.S. at 410; Brass v. North Dakota, 153 U.S. 391, 403 (1894).

[118] *See* CLARK, *supra* note 111, at 151-161 (describing appropriate bases for economic regulation apart from monopoly, including informational asymmetries, dependence on another's expertise, and providing a social minimum); WYMAN, *supra* note 5, ch. 2 (cataloging the varied justifications for imposing duties of fair treatment upon businesses and distinguishing "natural monopolies" from "virtual monopolies").

[119] *See* BREYER, *supra* note 13, at 15-16; *see also* GREGORY MANKIW, ESSENTIALS OF ECONOMICS 278 (6th ed. 2012) ("An industry is a natural monopoly when a single firm can supply a good or service to an entire market than could two or more firms.").

reasoned in upholding the constitutionality of a Kansas law fixing the rates for fire insurance:

> [T]he price of insurance is not fixed over the counters of the companies by what Adam Smith calls the higgling of the market, but formed in the councils of the underwriters, promulgated in schedules of practically controlling constancy which the applicant for insurance is powerless to oppose and which, therefore, has led to the assertion that the business of insurance is of monopolistic character and that it is illusory to speak of a liberty of contract.[120]

Far from insisting on what a modern economist would call a monopoly,[121] the Court approved Kansas's effort to constrain market power arising from another source—here, seemingly insurers' superior information about an opaque, complex financial product. *German Alliance* is not unusual. The case law, though littered with references to monopoly, was often inattentive to questions of market concentration.[122] All innkeepers, for example, were treated as affected with the public interest, however competitive the local market for inns.[123]

The law of public callings was organized not around an orthodox economic understanding of monopoly, but instead around a contestable

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[120] 233 U.S. 389, 416-17 (1914) (internal quotation marks omitted).

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[122] *See, e.g.*, New York v. La Fetra, 230 N.Y. 429, 445 (1921) (upholding rent regulation in New York and observing that "[t]he power of regulation [of prices] … is not limited to public uses or to property where the right to demand and receive service exists or to monopolies or to emergencies."); Brass, 153 U.S. at 403 ("When ... it is competent for the legislative power to control the business of elevating and storing grain … in cities of one size and in some circumstances, it follows that such power may be legally exerted over the same business when carried on in smaller cities and in other circumstances."); *see also* TUGWELL, *supra* note 109, at 66 ("Monopoly is almost never established as a fact in these cases, although it is often inferred. That it is inferred, not directly established, lends color to the theory that consumer disadvantage is in and by itself sufficient to establish public interest.").

[123] *See* Joseph W. Singer, *No Right to Exclude: Public Accommodations and Private Property*, 90 NW. U. L. REV. 1283, 1319-20 (1996) ("[N]o lawyer, judge, or treatise writer *ever* suggested that innkeepers in cities like Boston should be exempt from the duty to serve the public.").

political idea of power. The key was the "consumer disadvantage"[124] or "widespread oppression"[125] that could arise in the market. As Justice Stone observed in 1927:

> [E]ach of the decisions of this court upholding governmental price regulation . . . has turned upon the existence of a situation or a combination of circumstances materially restricting the regulative force of competition, so that buyers or sellers are placed at such a disadvantage in the bargaining struggle that serious economic consequences result to a very large number of members of the community.[126]

In the Progressive Era, the prevailing consensus was that the private market was shot through with such consumer disadvantage.[127] Public utility regulation thus became the dominant governance strategy for managing important industries that neither the market nor antitrust law could adequately discipline.[128]

3. Medicine's Absence.

Yet medicine was absent from even the most capacious lists of industries affected with a public interest. Why? If insurers and banks were regulated as public callings, why not hospitals and doctors? The

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[124] TUGWELL, *supra* note 109, at 92.

[125] La Fetra, 230 N.Y. at 429.

[126] Tyson v. Banton, 273 U.S. 418, 451-52 (1927) (Stone, J., dissenting).

[127] FRIED, *supra* note 3, at 25 ("The view that monopolies were becoming the rule rather than a limited exception to an otherwise competitive market … was widely shared among centrist and even conservative economists and political theorists.").

[128] *See* Walton Hamilton, *Affectation with Public Interest*, 39 YALE L.J. 1089, 1107 (1930) (suggesting that "the system of control may be set down as three presumptions, which are to be taken in order: price is to be left to free enterprise; the antitrust laws are to be used, if need be, to keep enterprise free; and, if free enterprise cannot be made to work, resort is to be had to formal price-fixing"); *see also* FRIED, *supra* note 3, at 112 ("By the early twentieth century, all but the strongest probusiness forces agreed that it was appropriate for the government to intervene in any business that was in the position to administer prices.").

answer is straightforward: prior to the Second World War, the medical industry lacked the sort of market power over essentials that called for state intervention.

The decades from 1870 through 1910 marked a period of enormous change for medicine.[129] At the close of the Civil War, hospitals in the United States little resembled the modern hospitals of today:

> These institutions were primarily the last resort of the sick. Their standards of care did not approach those for the simplest custodial care today. Hospital cleanliness was unknown, nursing was unskilled, equipment did not include even the clinical thermometer. The pills and potions of visiting staff physicians provided therapy. Major surgery was performed only in dire emergencies and was confined largely to fractures and amputations. … Patients dreaded the hospitals and surgeons distrusted themselves, so much so that the hospital system was at risk of passing out of society.[130]

Over the next forty years, medicine started to come into its own as a science. Medical schools became more rigorous and selective.[131] Doctors turned to hospital practice to enhance their public prestige and improve their private practice. Hospitals became slightly safer and began to proliferate. Although large public hospitals, often in urban centers, remained at the core of this growing hospital industry, the number of private, charitable hospitals—often called "voluntary hospitals"—surged. By 1909, 4,359 hospitals dotted the country, nearly the number in existence today.[132]

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[129] *See* COMMISSION ON FINANCING OF HOSPITAL CARE, FACTORS AFFECTING THE COSTS OF HOSPITAL CARE 8 (John H. Hayes, ed. 1954) ("[T]he general hospital, which had been essentially an institution for custodial care, began at the turn of this century to evolve into an institution in which the physician renders medical care.").

[130] *Id*. at 9 (internal quotation omitted).

[131] *See* STARR, *supra* note 2, at 116-23.

[132] *See* COMMISSION ON FINANCING OF HOSPITAL CARE, *supra* note 130, at 10; *compare* AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS 3 (2012 ed.) (identifying 4,995 non-federal U.S. hospitals in 2010).

Endowed by private philanthropists and supported by the state, the voluntary hospitals were regulated not as private businesses but as charities.[133] Consistent with hospitals' charitable mission, most patients were still housed in large, institutional wards; physicians typically didn't charge for their hospital-based practice; and many charitable hospitals still served a large percentage of indigent patients.[134]

As voluntary hospitals rose to prominence, however, the ancient association between hospital care and charity started to show strain. Financial pressures pushed voluntary hospitals to avidly seek out paying customers, particularly the well-off, to whom they provided private rooms and nicer amenities.[135] "From refuges mainly for the homeless poor and insane," Paul Starr explains, "[h]ospitals evolved into doctors' workshops for all types and classes of patients. From charities, dependent on voluntary gifts, they developed into market institutions, financed increasingly out of payments from patients."[136]

The law was slow to respond to hospitals' evolution from charitable entities to market actors. The sheer number of cases in which municipalities challenged the tax-exempt status of voluntary hospitals—because they demanded payment from all their patients, segregated paying patients from non-paying patients, or ran for-profit ventures alongside the non-profit hospital—suggests that many were not run along especially charitable lines.[137] And some courts did recognize the inherently public nature of private charities.[138] But the economic

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[133] *See* RESTATEMENT (SECOND) OF TRUSTS, §368(d) ("Charitable purposes include …. the promotion of health."); Jill Horwitz, *Does Nonprofit Ownership Matter?*, 24 YALE J. REG. 139, 148-50 (2007) (discussing history of charitable exemption).

[134] *See* COMMISSION ON FINANCING OF HOSPITAL CARE, *supra* note 130, at 12-13.

[135] *See* STARR, *supra* note 2, at 147.

[136] *Id*. at 146.

[137] *See* JOHN A. LAPP & DOROTHY KETCHAM, HOSPITAL LAW 5 (1926) (reporting that "[h]undreds of cases have been decided" on whether a hospital "is a charitable institution").

[138] *See, e.g.*, In re Nelson's Addition to Minneapolis, 27 Minn. 460 (1881) ("The word 'public' has two proper meanings. A thing may be said to be public when owned by the public, and also when its uses are public. The [private hospital]

regulation of public callings arose to curb the excesses of profit-making businesses that, by dint of their practical monopoly on important human needs, could exploit consumers. Charities fell in a different conceptual category: as one court put it in 1917, "the establishment of charitable hospitals is in no sense a recognized business."[139] For charities, the absence of a profit motive was thought to discourage the sorts of unfairness that could characterize private dealings.[140] There was no need for a law of public callings to smooth the edges of market competition when charitable hospitals stood outside that competition.

The charitable status of the voluntary hospitals thus distinguished them from the private, for-profit businesses that were regulated as public utilities. That distinction came under pressure not only because the voluntary hospitals behaved more and more like market actors,[141] but also because, in the early twentieth century, an increasing number of proprietary hospitals—private, for-profit hospitals, usually established by physicians as stand-alone surgical centers—started to crop up.[142] Although the law of charities had no application to these for-profit businesses, they undeniably served an important public function, much

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falls within this description of an institution of purely public charity. That patients who are able to pay are charged for hospital services according to their ability, and that the county pays for such services rendered to those who are a legal county charge, are facts of no importance upon the question as to the character of the institution as one of purely public charity; for the fact still remains, that, notwithstanding all receipts from such sources, the hospital is established, maintained, and conducted without profit or a view to profit, and that, on the whole, it is operated at a loss, which is necessarily made up by private contributions.").

[139] Lawrence v. Nisson, 91 S.E. 1036 (1917). *See also* Van Campen v. Olean General Hospital, 210 A.D. 204, 207 (N.Y. App. Div. 1924) ("That [voluntary hospitals] are engaged in charitable work for the benefit of the public, and thereby affected with a public interest, does not make them public corporations.")

[140] *See* Episcopal Academy v. Taylor, 150 Pa. 574 (1892) ("A private hospital, built and conducted as a business enterprise, stands upon widely different ground [from a charity]. There is no trust involved, no charitable use impressed upon such an establishment.").

[141] *See* ROSEMARY STEVENS, IN SICKNESS AND IN WEALTH 123 (1989).

[142] *See* STARR, *supra* note 2, at 219-20.

like railroads and banks. Were they properly classified as affected with a public interest?

The answer to that question went largely unanswered.[143] The sharp practices of private hospitals were simply not a salient legislative concern. For most of the period, a hospital stay was relatively cheap. In 1910, the average cost of a day in the hospital was just $2, or less than $50 today in inflation-adjusted dollars.[144] Concern with hospital charges first emerged in the 1920s,[145] when just 3.5% of gross national product went toward health care.[146] (That figure stands at 17.2% today.[147]) Yet, even in 1930, Walton Hamilton, a prominent supporter of state control of private enterprise, could still write that "there is little evidence that the price of bread, of clothing, *of medical service*, or of the talkies needs to become a matter of legislative concern."[148] In part because hospitalization wasn't that expensive, hospital insurance was nonexistent for most of the period, emerging only in the 1930s.

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[143] *See* STEVENS, *supra* note 143, at 129 ("State legislatures … had little interest in extending their authority over what appeared to be a successful mix of charitable, proprietary, and local-government general hospitals … ."). A comprehensive 1926 treatise on hospital law covers a wide range of topics, but makes no mention of the kind of economic regulation that was regularly directed at public callings. *See* LAPP & KETCHAM, *supra* note 138, at 209. Nonetheless, in a brief section in his treatise, Wyman averred that private hospitals were affected with the public interest: their activities, he explained, were "public in character." WYMAN, *supra* note 5, at 61

[144] COMMISSION ON FINANCING OF HOSPITAL CARE, *supra* note 130, at 13.

[145] *See* STARR, *supra* note 2, at 259.

[146] Randall R. Bovbjerg et al., *U.S. Health Care Coverage and Costs: Historical Development and Choices for the 1990s*, 21 J. LAW MED. & ETHICS 141, 142 (1993). Even by 1945, urban families spent just $150 on average per year on medical care. *See* JAMES T. PATTERSON, GRAND EXPECTATIONS: THE UNITED STATES, 1945-1974, at 12 (1996).

[147] *See* Anne B. Martin et al., *National Health Spending in 2012*, 33 HEALTH AFF. 67, 67 (2014).

[148] Hamilton, *supra* note 129, at 1100 n.54 (emphasis added).

The modesty of hospital charges reflected the limits of medical science.[149] Antiseptic surgery did not come widespread use until the end of the 19th century; penicillin, not until World War II. The ineffectiveness of medicine in the face of most disease meant that, "for most Americans, illness, injury, and early death were more to be suffered than helped by a doctor, much less insured against."[150] Only in the early decades of the twentieth century, according to the historian Rosemary Stevens, was medicine "beginning its long transition from a luxury to a necessity, from a privilege to a right."[151] Progressive reformers who worried about health concentrated not on medical care, but on public-health measures—occupational safety, improved sanitation, and control of contagious disease.[152]

For their part, physicians were unable to exercise the kind of market power that might have made them the targets of economic regulation. If physician prices were too high, Americans could go without medical care of dubious efficacy. Many did. For most of the period, too, physicians operated in a fierce competitive environment. The absence of licensing laws, compounded by the proliferation of thousands of medical schools willing to confer a degree upon paying students, complicated the profession's efforts to limit entry or consolidate its authority. As a result, physicians did not charge very much for their services, and the medical

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[149] Bovbjerg et al., *supra* note 149, at 141 ("Neither medicine nor health coverage was very advanced prior to the Great Depression. Accustomed to the medical miracles of the late 20th century, one tends to forget that 19th century doctors could do little for patients, and hospitals were mainly charity wards where the poor went to die.").

[150] *Id*. at 141; JAMES PATTERSON, GRAND EXPECTATIONS 353 (1997) ("[A]s late as the 1930s, [physicians] had been able to do little more than diagnose people and to console patients when they got sick … .").

[151] *See* ROSEMARY STEVENS, AMERICAN MEDICINE AND THE PUBLIC INTEREST 133 (1971); COMMISSION ON FINANCING OF HOSPITAL CARE, *supra* note 130, at 13 ("[A]s hospital care became increasingly expensive [from 1910 to 1935] it became more and more essential for those in all economic groups.").

[152] *See* WENDY E. PARMET, POPULATIONS, PUBLIC HEALTH, AND THE LAW 38 (2009) ("[P]ublic health's influence on American law was at its zenith during the Progressive era."); LEROY PARKER & ROBERT HOLLISTER WORTHINGTON, THE LAW OF PUBLIC HEALTH AND SAFETY (1892).

profession as a whole was not held in especially high esteem.[153] Far from wielding fearsome economic power, physicians were disciplined by the market.

Not until the late 1890s did physicians secure state licensing laws that restricted entry into the profession. Building on that foundation, physicians began a painstaking effort over the following decades to consolidate their status and power.[154] Although successful in the end, physicians had, by the eve of the Great Depression, only just begun to reap the benefits of their newfound power in the market. It was still the case that "physicians did not charge—or earn—large amounts. In 1929, for instance, the average net income for non-salaried physicians was some $5,200,"[155] or about $71,000 in today's dollars. (That figure stands at $191,000 today.[156]) Physicians saw that income drop nearly in half over the next decade.[157] In short, "in the era before health insurance, when patients themselves paid for almost all health care, the medical economy behaved much like the rest of the economy and was small relative to the whole."[158]

To contemporaries, the very idea that physicians were affected with a public interest might have seemed like a category error. The Progressive Era exhibited a deep faith in professionals, who were thought to operate outside the theater of business and to stand as a bulwark against the rapacity of private enterprise.[159] Much as the charitable orientation of the

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[153] *See* STARR, *supra* note 2, at 79-144.

[154] *Id.* at 232.

[155] Bovbjerg et al., *supra* note 149, at 142.

[156] *See* BUREAU OF LABOR STATISTICS, MAY 2012 NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATE STATISTICS, at http://www.bls.gov/oes/2012/may/oes_nat.htm#00-0000. By way of comparison, lawyers in 1929 earned on average about the same amount as physicians; today, they earn roughly one-third less. *See Professional Income: Lawyers and Dentists, 1929-48*, 70 MONTHLY LABOR REV. 396, 396 (1950).

[157] *See* Bovbjerg et al., *supra* note 149, at 142.

[158] *Id.*

[159] *See* HOFSTADTER, *supra* note 79, at 148-64; *see also* STARR, *supra* note 2, at 140 ("In the Progressive period, reformers and muckrakers crusading against

voluntary hospitals put them outside the category of private businesses affected with a public interest, so too did physicians' professional orientation make them an awkward fit for the category of public callings.

Nonetheless, in 1911, Wyman mused about whether medical care provided by physicians might be affected with a public interest. He closely examined the famous 1901 case of *Hurley v. Eddingfield*,[160] where the Indiana Supreme Court held in a terse opinion that a physician had no duty to treat a former patient who was in dire need. *Hurley*'s curt rejection of the claim that physicians might be likened to innkeepers or common carriers suggests that the analogy was farfetched. Wyman thought otherwise:

> When the need of the applicant is immediate the person from whom he asks service has the upper hand. This monopoly may only be temporary; but it is none the less real. Here again this classification of the authorities cannot as yet be safely taken as a generalization … . In [*Hurley*,] a physician was held not liable for refusing service to a patient in a desperate condition … [T]he need was urgent, and in the nature of things must always be. But perhaps in the community at present there are enough of such men always at hand to preclude the probability of injury by delay in the average case. Or perhaps the modern law balks at requiring personal service.[161]

Today, the casebooks present *Hurley* as an exemplar of the ancient common law rule that physicians owe no duty to treat.[162] Yet, even in 1911, when medicine was neither as effective nor as expensive as it is today, the laissez faire assumptions that animated *Hurley* were contested.

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business interests held up professional authority as a model of public disinterestedness.").

[160] 156 Ind. 416 (1901).

[161] WYMAN, *supra* note 5, at 86-87.

[162] *See, e.g.*, MARK A. HALL ET AL., HEALTH CARE LAW AND ETHICS 106, 113 (7th ed. 2007).

The lack of economic regulation of medicine prior to the mid-twentieth century says a great deal about the state of the medical industry in an earlier era. But it says very little about the American regulatory tradition, an important strand of which had long countenanced the close economic regulation of public callings. As medicine grew up over the course of the twentieth century, policymakers drew on this venerable tradition to regulate the burgeoning medical industry. It wasn't the tradition that had changed. It was medicine itself.

III. PUBLIC UTILITY REGULATION IN THE MEDICAL INDUSTRY

As medicine grew more technologically sophisticated, expensive, and indispensable in the postwar era, the business of medicine assumed the essential attribute of a public calling: it acquired the power to abuse its control over a necessity. It is no coincidence that, in the 1940s and 1950s, courts began holding that hospitals were "affected with a public interest."[163] By then, the constitutionality of economic legislation no longer turned on the label: in the 1934 case of *Nebbia v. New York*, the Supreme Court had discarded the "affected with a public interest" standard in assessing constitutionality.[164] The label nonetheless reflected growing concern that medicine had acquired market power that it lacked in an earlier era.[165]

The concern is more acute today. In Mark Hall and Carl Schneider's words, "enduring features of therapeutic relationships give rise to

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[163] *See, e.g.*, Northwestern Hosp. v. Public Bldg. Service Employees' Union, 208 Minn. 389, 294 N.W. 215 (Minn. 1940); West Coast Hosp. Ass'n v. Hoare, 64 So.2d 293 (Fla. 1953). Similarly, a 1939 Michigan statute regulated labor relations "where the employer is operating a public utility, or hospital, *or any other industry affected with a public interest*." Int'l Broth. of Elec. Workers v. State of Michigan Labor Mediation Bd., 294 Mich. 629 (1940) (quoting statute) (emphasis added).

[164] 291 U.S. 502, 536-37 (1934).

[165] *See* Tunkl v. Regents of University of California, 60 Cal. 2d 92, 98-100 (1963) (offering a litany of reasons, including the "essential nature of the service" and "superior bargaining power," for holding that a hospital contract was affected with a public interest); Greisman v. Newcomb Hosp., 40 N.J. 389, 397-99 (1963) (analogizing hospitals to innkeepers and common carriers in holding that they were "affected with a public interest").

monopolistic power that is ripe for exploitation."[166] To protect patients in that "desperate market," Hall and Schneider call on courts to reinvigorate the common law tradition, cataloged in Wyman's treatise, of imposing special duties on public callings.[167] But in focusing on judicial doctrine, Hall and Schneider may have downplayed the significance of a host of laws enacted in the postwar era that aimed to address the very problems they identify. This Part surveys prominent examples of these laws, organizing its discussion around the four duties of businesses affected with a public interest: to provide enough facilities to meet the public need, to serve all paying customers, to charge them nondiscriminatory rates, and to offer a fair price.[168] To a much greater extent that is commonly appreciated, health law bears the distinctive mark of the law of public callings.

To be clear, the claim is not that the entire business of medicine was once treated as a pure public utility. The economic regulation of physician practices, for example, has been and remains uncommon. Instead, such regulation has typically been directed at hospitals, which are responsible for the largest share of the nation's medical spending, as well as at insurers, which finance most medical care. Even there, public utility regulation has been incomplete, subjecting hospitals and insurers at varying times to more and less stringent duties to fairly serve the

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[166] Hall & Schneider, *supra* note 62, at 667.

[167] *Id*. at 666, 684 (citing WYMAN, *supra* note 5).

[168] *See* WYMAN, *supra* note 5, at xi ("[I]n public businesses one must serve all that apply without exclusive conditions, provide adequate facilities to meet all the demands of the consumer, exact only reasonable charges for the services that are rendered, and between customers under similar circumstances make no discriminations."); *see also* WILSON ET AL., *supra* note 99, at vii ("The obligation to render adequate service at reasonable and nondiscriminatory rates has long been recognized as a duty of public utility enterprises."); FREUND, *supra* note 89, at 382 ("Turning to the special control exercised over [businesses affected with a public interest], we find that it assumes one or more of the following forms: the regulation of charges; the requirement of equal service; requirements in the interest of public convenience; and requirements and restraints in the interest of financial security.").

public. Especially since the 1980s, much (but by no means all) such regulation has given way to a renewed faith in the market.[169]

The claim, instead, is that seemingly disparate state and federal laws can be understood, collectively, to reflect a coherent effort, characteristic of the public utility tradition, to curb the economic power of the medical industry by inhibiting the free use of its private property. In this, the laws stand as a rejection of the premise that the market will adequately meet the public need for accessible, fairly priced health care. They also belie the conventional assumption that treating medicine as a utility would break decisively with the American regulatory tradition.

1. Supply.

The years after the Second World War marked an inflection point for health care.[170] Medical advances, vividly on display among troops in combat, contributed to a felt need on the part of the government to assure that that returning soldiers and the civilians who had contributed to the war effort had access to needed care.[171] Yet hospital construction had stalled during the Depression, leaving the nation's hospital system in tatters, even as private hospital admissions more than doubled from 1935 to the end of the war.[172]

Building new hospitals could have been left to the private market. Because of the rapid spread of hospital insurance—virtually nonexistent in 1930, but covering more than 87 million people by 1951—hospitals were on a sounder financial footing than they had ever been before.[173]

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[169] *See* Rand Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155, 156 (2004) ("The market competition model developed in the early 1970s, began affecting policy very quickly, and became the dominant paradigm in the 1980s and 1990s.").

[170] *See* PATTERSON, *supra* note 153, at 67 ("Faith in medicine and in the goodness of physicians rose dramatically among the middle classes who could afford them.").

[171] *See* DAVID M. KENNEDY, FREEDOM FROM FEAR: THE AMERICAN PEOPLE IN DEPRESSION AND WAR, 1929-1945, at 716 (1999).

[172] *See* STEVENS, *supra* note 143, at 204; STARR, *supra* note 2, at 176-77.

[173] *See* SYLVIA LAW, BLUE CROSS: WHAT WENT WRONG 11 (1974).

Nevertheless, as the war came to a close, the mismatch between medical need and hospital supply led to a bipartisan call for hospital planning.[174] The push for planning reflected the view that the proper distribution of hospitals, with their newfound public importance, could not be left to the hurly burly of the market.[175]

Planning was first embraced as a national goal in 1946 with Congress's enactment of the Hospital Survey and Construction Act, more commonly known as Hill-Burton.[176] Building on state-level experiments with hospital planning begun in the 1920s,[177] Hill-Burton used the promise of federal money to encourage state planning agencies to survey the need for hospital construction and develop plans to meet that need.[178] The federal money was not insubstantial. Although the Act initially authorized just $75 million for hospital construction, the federal government would eventually spend $4.4 billion over three decades to build and upgrade medical facilities, amounting to roughly eight percent of the total costs of hospital construction nationwide.[179]

With federal money on the line, every state in the country (save Nevada) had, by 1948, submitted plans detailing their hospital needs.[180] These plans were meant not only to channel public subsidies, but also to

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[174] *See* STEVENS, *supra* note 143, at 173.

[175] *See* Charles A. Reich, *The Law of the Planned Society*, 75 YALE L.J. 1228, 1231-32 (1966) (linking the rise of planning to the regulation of public service corporations).

[176] *See* Title VI of the Public Health Service Act, Pub. L. 79-725, 60 Stat. 1040 (1946). For a general discussion, see STEVENS, *supra* note 143, at 216-24.

[177] *See* Sallyanne Payton & Rhoda M. Powsner, *Regulation Through the Looking Glass: Hospitals, Blue Cross, and Certificate-of-Need*, 79 MICH. L. REV. 203, 233 (1980).

[178] *See* Title VI, §601(a) (requiring state planning agencies to devise a plan for "furnishing adequate hospital, clinic, and similar services to all their people").

[179] *See* Committee on Interstate and Foreign Commerce, National Health Policy, Planning, and Resources Development Act of 1974, S. Rep. 93-1382, at 24, 26 (1974).

[180] *See* STEVENS, *supra* note 143, at 221.

guide development more generally.[181] "For the first time," the Surgeon General declared, "a national policy is established whereby hospitals and health centers are to be planned, located and operated in relation to the over-all health needs of the people."[182] As Stevens notes:

> On paper, at least the plans were impressive. … [T]he United States had a nationally defined, regionally organized network for hospital provision—a grid of lines of coordination across the country. The hospital plans, taken together, looked like plans for the national distribution of electricity. Hospitals were regarded as a national resource which should be organized rationally as a national system.[183]

During the 1960s, Hill-Burton was repeatedly amended to expand the role of state planning agencies and subsidize a wider array of construction.[184] As Hill-Burton changed focus, so too did health planning. Planning agencies were asked to assess (among other things) the need for community mental health facilities,[185] nursing homes,[186] rehabilitation facilities,[187] and neighborhood health centers.[188] In 1965, Congress

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[181] *See* INSTITUTE OF MEDICINE, HEALTH PLANNING IN THE UNITED STATES: ISSUES IN GUIDELINE DEVELOPMENT 10-11 (1980) (defining planning and distinguishing it from overt regulation).

[182] *Parran Sees Gains for Public Health*, N.Y. TIMES, Feb. 14, 1947.

[183] STEVENS, *supra* note 143, at 221.

[184] *See* DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, HILL-BURTON PROGRAM PROGRESS REPORT, JULY 1, 1947-JUNE 30, 1971, at 27 (1972) ("[T]he focus [of Hill-Burton] has shifted from the prime objective of providing general hospitals in rural areas, then to constructing sorely needed long-term care facilities for the growing numbers of chronically ill and aged, still later to the modernization of obsolete inpatient care facilities primarily in urban areas, and most recently to increased emphasis on outpatient facilities.").

[185] *See* Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, Pub. L. 88-164.

[186] *See* Hospital and Medical Facilities Amendments of 1964, Pub. L. 88-443.

[187] *See* Vocational Rehabilitation Amendments of 1968, Pub. L. 90-39.

[188] *See* Medical Facilities Construction and Modernization Amendments of 1970, Pub. L. 91-296.

allocated $600 million to regional medical programs that would coordinate treatments for heart disease, cancer, and stroke.[189] And in 1966, Congress overhauled the health-planning apparatus and earmarked $200 million for "comprehensive health planning" at the state level.[190] By the mid-1960s, health planning had entrenched itself as the preferred tool for channeling public subsidies toward areas of perceived need.

Yet planning in the Hill-Burton era lacked regulatory bite. Planning agencies could call for the construction of needed facilities and direct federal and state money toward desired projects, but they couldn't compel private hospitals or physician practices to do anything. "At best, health planning was viewed as inconsequential, and often it was irrelevant to the development of health care delivery, utilization of services or health care expenditures."[191] Perhaps for that reason, "[h]ospitals, physicians, and other who had feared and opposed the planning movement as the enemy of professional and institutional autonomy now saw it as a lesser evil than the growing threat of direct public regulation."[192]

Around the same time, skyrocketing medical spending was making it harder to defend Hill-Burton. Roemer's law—the theory, articulated by Milton Roemer, that "a built bed is a filled bed"[193]—came into vogue, suggesting that facility construction was itself contributing to medical spending.[194] The 1965 enactment of Medicare, which lavishly reimbursed hospitals and other institutional providers for their capital expenses, exacerbated the problem. Health planners began to see that assuring access to reasonably priced health care required more than public

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[189] *See* Heart Disease, Cancer, and Stroke Amendments of 1965, Pub. L. 89-239, 79 Stat. 926.

[190] *See* Committee on Interstate and Foreign Commerce, *supra* note 184, at 9.

[191] INSTITUTE OF MEDICINE, *supra* note 186, at 15 (quoting Herbert E. Klarman).

[192] *Id*.

[193] *See* Milton I. Roemer, *Bed Supply and Utilization: A Natural Experiment*, J. AM. HOSP. ASS'N 35 (1961).

[194] *See* INSTITUTE OF MEDICINE, *supra* note 186, at 7 (linking health planning, and limitations on supply, to Roemer's law).

subsidies and community meetings. Increasingly, planners sought to prevent heedless, duplicative facility construction.

Their primary technique for doing so—certificate-of-need (CON) legislation—reprised the Progressive Era innovation of demanding that public utilities secure "certificates of convenience and necessity" before constructing new facilities.[195] The idea behind CON is simple: prior to undertaking certain capital-intensive projects or purchasing expensive new equipment, hospitals or other medical facilities must secure a permit from a state planning agency. If the proposed investment is judged unnecessary to satisfy a local need for medical services, the permit is denied.

In 1966, a run of large premium increases for Blue Cross plans prompted New York to enact the nation's first CON law for the medical sector.[196] Over the next six years, twenty states followed suit.[197] In 1972,[198] and then more forcefully in 1974,[199] Congress enacted legislation to push for CON's nationwide adoption. CON quickly became ubiquitous.[200] As the Institute of Medicine reported in 1980, "[t]he certificate-of-need programs constitute the closest the United States comes to nationwide control of the supply of health services and the spread of expensive new technology."[201]

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[195] *See* WILSON ET AL., *supra* note 99, at 33 ("The public utility acts of practically all states provide that no person or corporation shall undertake and engage in the supplying of at least certain types of public utility service without first having obtained from the public service commission a certificate of public convenience and necessity."); Ford P. Hall, *Certificates of Convenience and Necessity*, 28 MICH. L. REV. 107, 107 (1929).

[196] *See* James B. Simpson, *Full Circle: The Return of Certificate of Need Regulation of Health Facilities to State Control*, 19 IND. L. REV. 1025, 1036 (1986).

[197] *See id*.

[198] *See* Social Security Amendments of 1972, Pub. L. 92-603, Sec. 221, §1122(a), 86 Stat. 1329, 1386.

[199] *See* National Health Planning and Resources Development Act of 1974, Pub. L. 93-641, 88 Stat. 2225.

[200] *See* Simpson, *supra* note 202, at 1055.

[201] INSTITUTE OF MEDICINE, *supra* note 186, at 19.

Anticipating that CON would form a key part of a reinvigorated health planning apparatus, Congress's 1974 legislation combined the various responsibilities that Congress had previously assigned to disparate planning agencies and handed them to a set of regional "health systems agencies."[202] Subject to oversight from statewide and national coordinating councils, these revamped agencies—there were usually three or four in each state—would distribute Hill-Burton funds, undertake comprehensive health planning, and coordinate regional medical programs.[203] By discouraging wasteful but remunerative investments, CON could spur investments in health-care resources that might otherwise be in scarce supply.

In the 1980s, enthusiasm for CON began to wane. As studies demonstrated that CON did little or nothing to control medical inflation, questions arose about its wisdom and necessity.[204] Concern mounted that dominant hospitals were exploiting CON to erect barriers to entry and squelch competition.[205] In addition, the 1983 reform of Medicare's hospital payment scheme and the steady proliferation of managed care organizations introduced new incentives for cost-containment into the health-care system, arguably diminishing the need for state oversight of capital expenditures. After the federal government repealed its pro-CON legislation, a number of states ended their programs.[206] Even so, CON

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[202] *See* Committee on Interstate and Foreign Commerce, *supra* note 184, at 31-32.

[203] *See* Social Security Amendments of 1972, Pub. L. 92-603, Sec. 221, §1122(d)(1), 86 Stat. 1329, 1387.

[204] *See, e.g.* Christopher J. Conover & Frank A. Sloan, *Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending*, 23 J. HEALTH POL. POL'Y & L. 455, 456 (1998) (observing that "a substantial amount of empirical evidence accumulated by the early 1980s indicat[ed] that CON regulations were ineffective in cost containment").

[205] *See generally* Payton & Powsner, *supra* note 182.

[206] *See* State Comprehensive Mental Health Services Plan Act of 1986, Pub. L. 99-660, §701.

was hardly abandoned. To this day, CON remains in place in roughly two-thirds of the states.[207]

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As Ernst Freund wrote in 1914, "[p]ublic service corporations must provide adequate facilities. The private corporation has no such duty."[208] First, with Hill-Burton, as a matter of aspiration and then, with CON, as a matter of regulation, health planning reflected the belief that the health-care industry had a duty to supply adequate facilities to meet the public need.[209]

2. Access.

Under the common law, "[a] private hospital owes the public no duty to accept any patient not desired by it, and it is not necessary to assign any reason for its refusal to accept a patient for hospital service."[210] The same is said to hold true for physicians.[211] Contrary to this accepted common law wisdom, however, hospitals and physicians are in fact legally obliged to serve many of those who seek their services. Because traits like race, religion, and disability supply the most common reasons for refusing service, the story of how the duty to serve became stitched into health law is in part a story about the development of the civil rights laws. But only in part. The service obligation doesn't just prohibit specific types of especially harmful discrimination. It is instead an affirmative duty to serve to the extent of the corporation's ability. In medicine, this broader access norm—one that, in effect, prohibits discrimination on

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[207] *See* Jill R. Horwitz & Daniel Polsky, *Challenges to Regulatory Decentralization: Lessons from State Health Technology Regulation*, fig. 1 (working paper, Nov. 2013).

[208] Freund, *supra* note 82, at 111.

[209] *See* STARR, *supra* note 2, at 376 ("In the United States, where planning has never been widely approved as a role for government, health planning was a limited exception.").

[210] 41 C.J.S. Hospitals, §8, p. 345 (quoted in Wilmington Gen. Hosp. v. Manlove, 174 A.2d 135 (Del. 1961)).

[211] *See* SARA ROSENBAUM ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM (2d ed. 2012).

almost any ground save ability to pay—has found expression through the special duties imposed on charitable hospitals and, more recently, through EMTALA.

a. Civil Rights.

Under the common law, private charitable hospitals were required to accept, within the limits of their capacities, members of the public on whose behalf the hospital had been established.[212] Often, that was the public at large: cases from the late nineteenth and early twentieth centuries regularly spoke of hospitals that do "not discriminate as to race, sex, or religion, but receiv[e] equally all who apply."[213] Yet the common law declined to extend a full-fledged service obligation. Hospitals established on behalf of a particular religion or race, for example, could restrict access to members of those groups.[214] And hospital trustees were empowered to select which members of the public they would serve. As the Massachusetts Supreme Court explained in 1876, "no person has individually a right to demand admission to [a charitable hospital's] benefits."[215]

That attitude slowly began to change after the Second World War. Building on the public orientation of charitable hospitals, Hill-Burton required the hospitals that received federal subsidies to make their facilities available on a non-discriminatory basis (albeit with a pre-Civil Rights-era allowance for separate-but-equal facilities). Hill-Burton also required those hospitals to provide "a reasonable volume of hospital services to persons unable to pay therefor,"[216] but this was understood to be aspirational. As James Blumstein has explained, Hill-Burton "was not

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[212] *See* Restatement (Second) of Trusts, §§372, 374 (1959).

[213] Philadelphia v. Pennsylvania Hospital, 8 Pa. C.C. 72 (1890); *see also* Lutheran Hosp. Ass'n v. Baker, 167 N.W. 148 (S.D. 1918); St. Joseph's Hosp v. Ashland County, 96 Wisc. 636 (1897); Sisters of St. Francis v. Board of Review, 231 Ill. 317, 318 (1907); Hot Springs School District v. Sisters of Mercy, 106 S.W. 954, 954 (Ark. 1907).

[214] LAPP & KETCHAM, *supra* note 138, at 213.

[215] McDonald v. Mass. Gen. Hosp., 120 Mass. 432 (1876).

[216] Public Health Service Act, Pub. L. 79-725, §622(f), 60 Stat. 1040, 1041 (1946).

designed as a program to pay for indigent care. It was a program designed to develop facilities to which access would be available to all on a nondiscriminatory basis."[217] To put it slightly differently, Hill-Burton was not social-welfare legislation. It reflected the sort of economic regulation to which public callings had long been subjected.

Hill-Burton was just the beginning. Two decades later, the Civil Rights Act of 1964 marked a historic advance. With the connection to health care "prominent in the minds of its authors,"[218] Title VI of the Act prohibited discrimination in any programs receiving federal financial assistance.[219] The enactment of Medicare and Medicaid the following year made Title VI a powerful tool to induce hospitals to offer medical services to the public on a nondiscriminatory basis.[220] Even here, however, the step was only partial. Bowing to political pressure, the Johnson administration declined to characterize Medicare payments to physicians as federal financial assistance.[221] And Title II of the Act, which prohibited discrimination on the basis of race, religion, or sex in "public accommodations," pointedly did not extend to hospitals and physicians' offices.[222] Under federal law and most state laws, physicians thus remained free to discriminate.[223]

Twenty-six years after the enactment of the Civil Rights Act, the Americans with Disabilities Act of 1990 (ADA) marked a transformative step in bringing the access norm to medicine.[224] Like the Civil Rights Act,

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[217] James F. Blumstein, *Court Action, Agency Reaction: The Hill-Burton Act as a Case Study*, 69 IOWA L. REV. 1228-29 (1984).

[218] Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System*, 3 YALE J. HEALTH POL. POL'Y & LAW 215, 220 (2003).

[219] Civil Rights Act of 1964, 88-352, tit. VI.

[220] *See* DAVID BARTON SMITH, HEALTH CARE DIVIDED 115-21 (1999).

[221] *See* Joel Teitelbaum & Sara Rosenbaum, *Medical Care as a Public Accommodation: Moving the Discussion to Race*, 29 AM. J. L. & MED. 381, 382 & n.8 (2003).

[222] Civil Rights Act of 1964, 88-352, tit. II.

[223] *See* Teitelbaum & Rosenbaum, *supra* note 225, at 386 & n.28 (noting that the twenty states with public accommodations laws didn't cover hospitals or physicians' offices).

[224] *See* Americans with Disabilities Act of 1990, Pub. L. 101-336, 104 Stat. 327.

the ADA also prohibited discrimination in public accommodations. Unlike the Civil Rights Act, however, the ADA included hospitals and physicians' offices within the scope of its protections.[225] By 1990, this extension of public-accommodations law to medicine was so uncontroversial as to pass almost unnoticed.[226]

b. Revenue Rulings.

Although the civil rights laws made inroads on the classical view that property owners have an absolute right to exclude, they aimed primarily to eradicate institutional discrimination against disfavored groups. As such, the civil rights laws overlap with, but are distinct from, the service obligation. In some respects, the service obligation is narrower: businesses not typically thought to be "affected with a public interest"—barber shops and grocery stores, for example—are still subject to civil rights laws. In other respects, the service obligation is broader: where it applies, it not only prohibits discrete types of discrimination, but imposes an affirmative duty to serve.

As early as 1956, that broader duty began to be imposed in the health-care sector through the vehicle of federal tax law.[227] In a significant revenue ruling, the IRS determined that voluntary hospitals, which accounted for two-thirds of all hospital admissions in the country,[228] would be considered charitable (and thus tax-exempt) only if they were "formed for the purpose of furnishing hospital facilities to *all persons* in the community at the lowest possible cost."[229] The revenue ruling thus reflected a legal recognition that charitable hospitals could not exclude patients at will.

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[225] 42 U.S.C. §12181 (defining "public accommodation," for purposes of the ADA, to include "professional office[s] of a health care provider" and "hospital[s]").

[226] *See* Teitelbaum & Rosenbaum, *supra* note 225, at 389.

[227] For a discussion of the revenue rulings, see Horwitz, *supra* note 134, at 151-52.

[228] *See* F.H. Arestad & Mary A. McGovern, *Hospital Service in the United States*, 152 J. AM. MED. ASS'N 143, 144 (1953).

[229] Rev. Rul. 56-185, at 3 (1956) (emphasis added).

The service obligation assumed greater prominence in a 1969 revenue ruling that updated the IRS's rules on non-profit hospitals. Two features of the 1969 ruling are noteworthy. First, the ruling obligated charitable hospitals to treat Medicare and Medicaid beneficiaries.[230] The duty to serve those patients thus increased the pressure on non-profit hospitals to accept federal funding—funding that would, in turn, expose them to the strictures of Title VI of the Civil Rights Act. Second, the revenue ruling required non-profit hospitals to operate "an emergency room open to all persons." The connection here to the law of public callings is unmistakable.[231] Having built a hospital and opened it to the public, the law imposed a duty to offer a needed public service (a blunt form of health planning) and to serve all in need of that service.[232]

c. EMTALA.

The conjunction of the civil rights laws, the revenue rulings, and the enactment of Medicare and Medicaid reflected only a partial adoption of the service obligation in medicine. In the mid-1980s, highly publicized incidents of "patient dumping"—the practice of refusing medical services to those in emergency conditions who couldn't afford care[233]—prompted Congress to enact the Emergency Medical Treatment and Active Labor

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[230] *See* Rev. Rul. 69-545, at 3 (1969) (requiring treatment "for all those persons in the community able to pay the cost thereof either directly or through third party reimbursement"); Eastern Kentucky Welfare Rights Organization v. Simon, 506 F.2d 1278 (D.C. Cir. 1974) (noting that "hospitals seeking to qualify as charities pursuant to Revenue Ruling 69-545 must accept Medicare and Medicaid patients").

[231] *See* Mark A. Hall, *The Unlikely Case in Favor of Patient Dumping*, JURIMETRICS J. 389, 390 (1988) ("Largely due to the conception of hospitals as businesses affected with the public interest, for decades these institutions have been subject to numerous sources of law that impose more scrutiny on their criteria for patient selection.").

[232] In 1983, the IRS softened somewhat the obligation to operate an emergency room, but only when a state planning agency found that opening another emergency room would be "unnecessary and duplicative." Rev. Rul. 83-157.

[233] *See* David A. Hyman, *Patient Dumping and EMTALA*, 8 HEALTH MATRIX 29, 32 (1998).

Act (EMTALA).[234] As a condition of participating in Medicare, EMTALA requires hospitals with emergency rooms, as well as their on-call physicians, to treat any person who either has an emergency medical condition or is in advanced labor.[235] Because Medicare participation is a financial necessity for nearly all hospitals, and because the treatment duty extends to the general public, not just Medicare beneficiaries, EMTALA imposes what is, in effect, a limited service obligation on all hospitals.

EMTALA mirrored a number of state-court decisions holding that, under the common law, emergency rooms must accept for treatment anyone who presents with an emergency condition.[236] Some of those decisions were premised on the conclusion that hospitals were affected with a public interest.[237] Still others invoked the reliance interests that were arguably implicated when emergency rooms held themselves out as open to the public[238]—a move that features prominently in cases involving public callings.[239]

In the years after its enactment, EMTALA has come in for serious academic criticism. EMTALA may encourage hospitals to shut their emergency rooms.[240] Hospitals may cope with EMTALA's unfunded obligation by inflating prices for paying patients, many of whom cannot pay more for their care.[241] And the law papers over the problem of the

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[234] Consolidated Omnibus Reconciliation Act of 1985, Pub. L. 99-272, §9121 (codified as amended at 42 U.S.C. §1395dd).

[235] *See* 42 U.S.C. §1395dd(d)(1).

[236] *See* Hall, *supra* note 238, at 390 ("Since the *Manlove* decision in 1961, no court has refused to require at least stabilizing care in a serious emergency, and several decisions have gone much further.").

[237] *See* Thompson v. Sun City Community Hospital, 141 Ariz. 597 (1984); Payton v. Weaver, 182 Cal. Rptr. 225 (Cal. Ct. App. 1982).

[238] *See* Wilmington General Hospital v. Manlove, 174 A.2d 135 (Del. 1961).

[239] *See* Singer, *supra* note 124, at 1308.

[240] *See* RICHARD EPSTEIN, MORTAL PERIL 95-98 (2000).

[241] *See* Robert A. Carolina & M. Gregg Bloche, *Paying for Undercompensated Care: The Regressive Profile of a Hidden Tax*, 2 HEALTH MATRIX 141 (1992).

uninsured.[242] As David Hyman reports, however, "[t]he statute is wildly popular across the entirety of the political spectrum, and among such disparate interest groups as physicians, advocates for the poor, professors of law and public health, and consumer groups."[243] EMTALA owes its popularity to the deeply felt and widely shared belief that private hospitals violate a public trust when they refuse medical care to those in need.

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The service obligation in medicine is by no means fully developed. The civil rights laws protect only against discrimination on certain protected grounds; the rules for charitable organizations demand treatment only of Medicare and Medicaid beneficiaries; and EMTALA applies only to emergency services. As the authors of a leading casebook speculate, "[p]erhaps this body of law is not more developed because doctors and hospital rarely turn away patients who can pay."[244] Nevertheless, taken as a whole, the network of laws regulating access to medical services reflects the impulse that private actors serving important needs owe a legal duty to serve the public.

3. Nondiscriminatory rates.

As an adjunct to the service obligation, the law has traditionally required public service corporations to charge the same rates for the same services. Otherwise, the service obligation would be of little value: private businesses could either gouge those in desperate need or hike their prices for those whom they preferred not to serve.

In contrast to health planning and the service obligation, prohibitions on price discrimination have not taken hold when it comes to the direct regulation of hospitals and other providers. By and large, providers retain wide freedom to charge different patients different prices.[245] Yet few

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[242] *See* Hall, *supra* note 238, at 394-95.

[243] Hyman, *supra* note 240, at 29.

[244] HALL ET AL., *supra* note 166, at 117.

[245] State restrictions on "balance billing"—the practice of charging patients more than what Medicare or Medicaid pays for their services—are a limited exception.

people pay directly for medical services. In the private market, most get insurance either through their employer or, less commonly, on the individual market. Because the insured are insulated from the full price of their care, discriminatory pricing at the hospital or in a physician's office may not be an urgent concern.

The pricing practices of insurers are more worrisome. An insurer that charges actuarially fair rates will, of necessity, charge the old and unhealthy more for insurance than the young and healthy. Whether "experience rating" amounts to price discrimination in the classical sense is contestable: even if the terms and benefits package of two health plans are identical, the plan sold to the sicker person is, as an actuarial matter, quite different from the plan sold to the healthier person.[246] Many consumers nonetheless view experience rating as unfair discrimination on the basis of health.

Experience rating was not a feature of health-insurance market when it first arose in the 1930s. The voluntary hospitals, confronted with a funding crisis arising from the confluence of rising medical costs and the Depression, moved to establish Blue Cross organizations to serve as their financing arms. Aligning themselves with the community orientation of the voluntary hospitals, these early Blue Cross organizations charged a single, uniform "community rate."[247]

That didn't last long, however. When Blue Cross proved the success of the business model, private insurers quickly entered the market. That put Blue Cross plans in an unenviable spot. Because healthier people were attracted to the new, experience-rated plans, Blue Cross plans had to hike their premiums to cover the larger medical costs of their relatively unhealthy enrollees. Doing so, however, only drove more healthy people

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See, e.g., Mass. Med. Soc. v. Dukakis, 815 F.2d 790 (1st Cir. 1987) (upholding such a statute).

[246] *See* BREYER, *supra* note 13, at 17 ("'Price discrimination' means, say, charging different customers two or more different prices for the identical product.").

[247] *See* LAW, *supra* note 177, at 6, 11.

away. By the mid-1950s, Blue Cross plans relented to market pressure and, like the private insurers, began to experience rate.[248]

The desire to guard against "unfair" price discrimination in the insurance market has prompted a number of legislative interventions. In the early 1990s, the harshness of experience rating—especially for small businesses, which could find insurance out of reach if a single employee contracted a high-cost illness—provoked forty-five states to limit insurers' ability to discriminate on the basis of health status in the small-group market.[249] A handful of those states, including New York, mandated pure or nearly pure community rating in the individual and small-group markets.[250]

The federal government soon got into the reform game. In the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Congress prohibited employers from crafting eligibility rules or raising a worker's premiums based on their health status.[251] HIPAA thus served as an employer-specific prohibition on price discrimination. The enactment of the Genetic Information Nondiscrimination Act of 2008 went a small step further in barring employers and insurers from using genetic information to deny coverage or increase premiums.[252] And the ACA went much further by prohibiting all insurers in the small-group and individual markets—not only those on the exchanges, but all insurers—from experience rating.[253] Insurance premiums can still vary based on

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[248] *See* Herman M. Somers & Anne R. Somers, *Private Health Insurance: Part Two*, 46 CALIF. L. REV. 508, 514 (1958).

[249] *See* Thomas Buchmuller & John DiNardo, *Did Community Rating Induce an Adverse Selection Death Spiral? Evidence from New York, Pennsylvania, and Connecticut*, 92 AM. ECON. REV. 280, 280 (2001).

[250] *See* OFFICE OF HEALTH POLICY, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, THE REGULATION OF THE INDIVIDUAL HEALTH INSURANCE MARKET, at 24-26 (Winter 2008), at aspe.hhs.gov/health/reports/08/reginsure/report.pdf (identifying seven states that mandate some form of community rating in the individual market and eleven states that do so in the small-group market).

[251] Pub. L. 104-191, Sec. 101, §702, 110 Stat. 1936, 1945.

[252] Pub. L. 110-233, 122 Stat. 881.

[253] *See* ACA, Sec. 1201, §2701.

geography, family status, tobacco use, and age.[254] Otherwise, insurers must offer the same rate to all comers. In this, the ACA represents a partial extension of the public utility model into medicine.[255] The ACA, however, draws the line at insurers, eschewing public utility regulation when it comes to physicians, hospitals, and other providers.

4. Fair rates.

As with other aspects of the public utility model, rate regulation became prominent in the medical industry in the second half of the twentieth century. The earliest price controls came through the oversight of Blue Cross plans. A handful of state insurance commissioners—seven in 1974—had the authority to review the rates that Blue Cross plans charged to assure they were not "excessive, inadequate, or unfairly discriminatory."[256] Eleven more required rates to be "fair and reasonable."[257] Most exercised the authority gingerly, but a few, including Pennsylvania, pushed hard to curb Blue Cross premiums.[258]

These early efforts to control medical spending were not terribly effective. As medical inflation continued to escalate, attention shifted to direct oversight of hospital rates. Starting with New York in 1969, eight states, concentrated in the northeast, moved over the next decade to impose price controls on hospitals.[259] At least nineteen more asked state officials to monitor hospital prices.[260] Four states—New York, New

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[254] *Id*.

[255] *See* Rosenbaum, *supra* note 9, at 1882 ("The [ACA] fundamentally transforms health insurance from a product designed to preserve profitability in the face of rampant adverse selection to a regulated industry whose long-term strength and stability are essential to the public interest and that, in its restructured form, will therefore take on certain characteristics of a public utility.").

[256] LAW, *supra* note 177, at 13.

[257] *See id*.

[258] *See id*. at 17, 112-13.

[259] *See* Frank A. Sloan, *Rate Regulation as a Strategy for Hospital Cost Control*, 61 MILBANK MEMORIAL FUND QUARTERLY 195, 198 (1983).

[260] *See id*. at 198.

Jersey, Massachusetts, and Maryland—took an especially comprehensive approach to rate regulation. They fixed not only the rates that private insurers and Medicaid would pay for hospital services, but also secured federal waivers requiring Medicare to pay hospitals at the state-regulated rates. In the 1970s, this "all-payer rate-setting" came to dominate the debate over how to restrain hospital prices.[261]

"In no state was the 'public utility' model of rate regulation more conspicuous than in the Empire State."[262] Enacted in large part to cut cripplingly large Medicaid expenditures, New York's price control laws initially targeted the rates that hospitals could charge Blue Cross and Medicaid. As Sylvia Law explained in 1974:

> The theory of the New York cost control plan is that, in the absence of competitive market influence, an incentive-penalty mechanism is needed to keep hospital prices down. The incentive is the amount of money the hospital can plan on and retain if its annual costs total less than its budget projection. Similarly, the amount by which a hospital's costs exceed its projected budget becomes a financial penalty which the hospital must absorb.[263]

Over the next decade, New York gradually expanded the scope of its price controls until it included all payers, including Medicare.[264]

New Jersey tackled rate regulation somewhat differently. Rather than capping overall hospital budgets, New Jersey demanded that hospitals change how they billed for care. No longer could they bill per service or per day; instead, hospitals in New Jersey would bill per case. Under this new diagnosis-related group (DRG) system, hospitals would charge a fixed sum for treating a patient with a particular condition (say, acute

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[261] *See* Gerard F. Anderson & Samuel A. Mitchell, *All-Payer Ratesetting: Down But Not Out*, HEALTH CARE FINANCING REVIEW (1991) ("All-payer ratesetting for hospitals was at the center of the policy paradigm for controlling health care costs during the 1970s.").

[262] *See* Robert B. Hackey, *Regulatory Regimes and State Cost Containment Programs*, 18 J. OF HEALTH POL. POL'Y & LAW 491, 495 (1993).

[263] LAW, *supra* note 177, at 105.

[264] *See* Anderson & Mitchell, *supra* note 268.

pneumonia), giving the hospital an incentive to treat conservatively. New Jersey's experiment with per-case pricing served as the foundation for Medicare's shift to DRGs in 1983. But where Medicare used DRGs to shift responsibility for controlling costs to hospitals, New Jersey remained tightly committed to a public utility model of rate regulation.[265] It is no accident, as Bruce Vladeck has noted, "that the statute creating the New Jersey DRG system is in fact literally an amendment to the state's health planning law."[266]

Experience in New York and New Jersey convinced many observers in the 1970s that price controls were inevitable.[267] In an effort to fend off federal oversight, the American Hospital Association established an Advisory Panel on Public Utility Regulation and, in 1972, accepted the panel's endorsement of model legislation that would establish independent rate-regulation commissions at the state level.[268] Two years later, Congress authorized grants for states to explore rate regulation.[269] And in 1977, President Carter, as a cornerstone of his effort to tackle inflation, proposed federal legislation that would—as he explained in a message to Congress—"restrain increases in the reimbursements which hospitals receive from all sources: Medicare, Medicaid, Blue Cross,

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[265] *See* Bruce Vladeck, *Diagnosis-Related Group-Based Hospital Payment: The Real Issues*, 62 BULL N.Y. ACAD. MONTHLY 46, 47 (1986).

[266] *Id*. at 53-54.

[267] *See* Lawrence D. Brown, *Political Evolution of Federal Health Care Regulation*, 11 HEALTH AFF. 25 (1992) ("Hospital association heads believed, and persuaded their constituents, that federal rate regulation was on its way and that they might claim exemption for their homegrown systems when that unhappy day arrived.").

[268] *See* AMERICAN HOSPITAL ASSOCIATION, GUIDELINES FOR REVIEW AND APPROVAL OF RATES FOR HEALTH CARE INSTITUTIONS AND SERVICES BY A STATE COMMISSION (accepted by Board of Trustees Feb. 9, 1972).

[269] *See* National Health Planning and Resources Development Act of 1974, §1526, Pub. L. 93-641, 88 Stat. 2225 (1975).

commercial insurers, and individuals."[270] Under pressure from the hospital industry, the bill was narrowly defeated in 1979.[271]

The defeat of Carter's bill was a harbinger of a sharply diminished appetite in the 1980s for all-payer rate-setting. Starting with Wisconsin in 1986, nearly every state moved to dismantle its rate-setting apparatus.[272] Today, only two states—Maryland and West Virginia—still impose price controls on hospitals, and Maryland's ability to sustain its system depends on a statutory waiver requiring Medicare to pay Maryland hospitals based on state-negotiated rates (and, not incidentally, allows Maryland providers to reap an additional $200 million every year in Medicare payments).[273]

Significantly, however, all-payer rate-setting was not discarded because it had been proven ineffective. To the contrary, numerous studies showed that rate-setting reduced per-capita and per-discharge prices, although the evidence was mixed as to whether price controls reduced overall medical expenditures.[274] Instead, as John McDonough has argued, managed care killed price controls.[275] Managed care organizations were expected to negotiate forcefully with providers over prices. Because rate regulation would interfere in those market negotiations, the waxing of managed care led to the waning of price controls.

More generally, the surging interest in managed care in the 1980s reflected a renewed faith in the market and a growing distrust of government solutions to complex social problems. That distrust extended

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[270] Jimmy Carter, Health Care Legislation Message to the Congress, Apr. 25, 1977, at http://www.presidency.ucsb.edu/ws/?pid=7401 (discussing Hospital Cost-Containment Act of 1977, H.R. 6575, 95th Cong., 1st Sess. (1977)).

[271] *See* Steven V. Roberts, *House Unit Defeats a Proposal to Curb Hospital Cost Rises; Major Setback to President*, N.Y. TIMES, July 19, 1978.

[272] *See* John E. McDonough, *Tracking the Demise of Hospital Rate Setting*, 16 HEALTH AFF. 142, 143-44 (1997).

[273] *See id*. at 145.

[274] *See* Anderson & Mitchell, *supra* note 268 (1991) (reviewing studies); KAREN DAVIS ET AL., HEALTH CARE COST CONTAINMENT 100 (1990) (same).

[275] *See* McDonough, *supra* note 279, at 142.

to rate-setting schemes, which were so complex that they fostered suspicions that powerful hospitals manipulated them to their own advantage.[276] In this newly skeptical environment, supporters of all-payer rate-setting became "defensive about acknowledging the parallels to public utility regulation."[277] Policymakers became so disenchanted with rate-setting by the early 1990s that all-payer rate-setting virtually vanished from the public conversation.[278] As McDonough explains, "[t]he public utility model for hospitals, popular with many rate-setting pioneers, is a direct casualty in this transition."[279]

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In sum, public utility regulation has formed a strong undercurrent of medical regulation in the modern era, particularly in the period from 1945 to 1980. The supply of medical resources has been overseen; public access has been guaranteed; price discrimination has been curbed; and rates have been regulated. Because the public utility model is now out of fashion, the extent to which it has shaped the regulation of medicine has been obscured. For similar reasons, the policy debate today has distanced itself from the possibility of treating medicine as a public utility. Yet, even before the advent of hospital rate regulation, A.J.G. Priest, the author of the then-leading treatise on public utilities, wrote a brief article arguing that health care ought to be considered—indeed, was already being treated as—a public utility:

> Why would regulation of the health care industry be analogous to the fixing of public utility rates and practices? Basically, because the business of health care is deeply and intimately affected with a public interest, because hospitals and like institutions have the power of exploitation in some measure, even though it is not frequently exercised, and because such instrumentalities carry on

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[276] *See id*. at 144.

[277] Vladeck, *supra* note 272, at 48.

[278] *See* Anderson & Mitchell, *supra* note 268 (noting that, by the 1990s, "the discussion of all-payer ratesetting in national policy circles was almost nonexistent").

[279] McDonough, *supra* note 279, at 148.

> what is in some respects a natural monopoly. And, as has long been recognized as a matter of economics as well as law, when a necessity of life is provided by a monopoly or quasi-monopoly, effective regulation of that enterprise is required to protect the public interest.[280]

Priest thought it inevitable that such effective regulation was coming down the pike: "There seems to be no other feasible remedy for soaring hospital prices."[281]

IV. THE RISE OF PUBLIC UTILITY REGULATION?

History took a different turn than Priest anticipated. Growing interest in market-based solutions in the late 1970s and 1980s, a distrust of the cartelization that could arise from single-industry regulation, the political power of organized medicine, and the rise of managed care all contributed to renewed skepticism about the wisdom of treating the medical industry as a public utility. For medicine, approaches that attempt to leverage market forces—not restrain them—have been dominant for three decades.[282]

The tide may be turning, however. The turn is hard to see in part because, in today's political climate, the adoption of the public utility model at the federal level seems quite unlikely. But the recent, relentless focus on federal law, stoked by the long debate over the ACA and its tumultuous implementation, may have distracted from the possibilities of state intervention. Even after the ACA's reshaping of the insurance markets, states retain the authority to regulate hospitals, physicians, and other providers. Not all states will embrace public utility regulation. But might it play an increasingly important role in some?

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[280] Priest, *supra* note 9, at 840.

[281] *Id*. at 841, 848.

[282] *See* HACKER, *supra* note 15, at 156 ("The importance of the neoclassical critique to the prevailing intellectual framework of the health policy community helps explain the level of acceptance that has greeted the managed-competition approach.").

Without question, political views about the propriety and wisdom of economic regulation will influence whether states move toward the public utility model. Texas will probably be less enamored of the approach than California. But public utility regulation may also be more attractive in those states with more dysfunctional health-care markets. Exorbitant insurance prices, for example, are an urgent concern in large parts of Connecticut, Colorado, and Wisconsin.[283] Similarly, access concerns are expected to be more acute in sprawling rural states—including New Mexico, Idaho, and Nevada—than in smaller states with large urban and suburban populations.[284]

Heterogeneity of preferences and circumstances among the states partly explains why they have historically taken the lead in adapting public utility regulation to medicine. Health planning and CON legislation, although supported by the federal government, were both state-level efforts. State public accommodations laws and emergency-care obligations antedated the Civil Rights Act of 1964 and EMTALA. A number of states moved ahead with community rating in the insurance markets prior to the enactment of the ACA. And New York, New Jersey, and Massachusetts were trailblazers for hospital rate-setting.

A new generation of public utility regulation need not mimic these older interventions. But the states might, for example, reform their CON laws to more closely superintend provider consolidation, the construction of expensive facilities, or the acquisition of novel technologies. Or they might enact legislation forcing insurers to accept any willing providers into their networks. Or they might establish commissions to monitor provider prices and, perhaps, even fix rates.[285] Designing institutions that could competently oversee the sprawling medical marketplace and successfully resist pressure from the medical industry would be no easy

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[283] *See* Jordan Rau, *The 10 Most Expensive Health Insurance Markets in the U.S.*, KAISER HEALTH NEWS, Feb. 3, 2014.

[284] *See* Huang & Finegold, *supra* note 20, at 615.

[285] For an extended, pre-ACA discussion of how cost controls and entry restrictions in use in other countries could be adapted for the United States, see WHITE, *supra* note 17, at 271-90.

feat.[286] But states confronted with rank unfairness in their health-care markets may come to feel that they have no real alternative.

Whatever the precise contours of state intervention, public utility regulation today would have one advantage over earlier efforts. Instead of focusing on hospitals and neglecting physicians and alternative care settings, public utility regulation could target the large medical systems that are coming to dominate the health-care landscape. Not only would that enable economic oversight of services offered outside the hospital. Better still, the states could press those medical systems to adopt pricing models—including fixed budgets or bundled payments—that would encourage care coordination and undermine the pernicious incentives of the fee-for-service system. It's happened before: in 1970s, New Jersey's rate regulators developed the hospital payment system that Medicare still uses.

Even now, it is possible to discern a renewed interest in public utility regulation, especially, but not exclusively, at the state level. The impending physician shortage, for example, has rekindled interest in health planning, and specifically in efforts to address perceived inadequacies in the practitioner workforce.[287] For now, planning efforts are largely confined to financial inducements. The ACA, for example, appropriated $11 billion dollars over five years to support community health centers and the National Health Service Corps, both of which aim to make medical care more readily available in under-resourced areas.[288] And the adoption of pricey technology of dubious medical value—including, in particular, proton-bear accelerators with price tags of $100 million or more[289]—has also spurred renewed attention to CON.[290]

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[286] *Cf.* Rachel E. Barkow, *Insulating Agencies: Avoiding Capture through Institutional Design*, 89 TEX. L. REV. 15 (2010).

[287] *See* John K. Iglehart, *A New Day Dawns for Workforce Redesign*, 32 HEALTH AFF. 1870, 1870 (2013).

[288] *See* ACA, §10503, as amended by Reconciliation Act, §2303

[289] *See* Amitabh Chandra et al., *Is This Time Different? The Slowdown in Healthcare Spending*, NAT'L BUREAU OF ECON. RES., at 48 (2013), at http://www.nber.org/papers/w19700; Jaimy Lee, *Proton-beam Centers Sprout Despite Evidence Drought*, MODERN HEALTHCARE, Apr. 12, 2014.

Access concerns prompted by the exclusion of large hospital systems from insurer networks have also provoked a response from state policymakers. Mississippi, Pennsylvania, South Dakota, and New Hampshire have all given serious consideration to bills that would require insurers to accept into their networks any provider willing to accept their terms.[291] In addition, some state insurance commissioners have indicated that they will more assertively oversee insurer networks to "make sure when people purchase health insurance, they have reasonable access to health-care providers," as California's commissioner put it.[292] Earlier this year, New York adopted a law protecting patients from surprise bills if they get treatment from out-of-network providers when in-network providers were unavailable to treat them.[293] And the Obama administration recently announced that it would cooperate with state insurance commissioners to craft stringent new rules to assure the adequacy of provider networks on the exchanges.[294]

Nascent interest in regulating prices can perhaps be seen in the rapid proliferation of public databases, all-but unknown just a decade ago, that collect information about the rates that private insurers pay for treatment. Frustrated at the secrecy shrouding charges that providers negotiate with

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[290] *See* TRACY YEE ET AL., HEALTH CARE CERTIFICATE OF NEED (CON) LAWS: POLICY OR POLITICS?, NAT'L INST. FOR HEALTH CARE REFORM RESEARCH BRIEF (May 2011) ("[T]here is renewed interest in certificate-of-need regulation as a way to improve health planning and help control spending growth."); Michael D. Rosko & Ryan L. Mutter, *The Association of Hospital Cost-Inefficiency with Certificate-of-Need Regulation*, 7 MED. CARE RES. & REV. 280 (2014) (reporting results "suggest[ing] that CON regulation may be an effective policy instrument in an era of a new medical arms race").

[291] *See* Jay Hancock, *Narrow Networks Trigger Push-Back from State Officials*, KAISER HEALTH NEWS, Nov. 25, 2013.

[292] Anna Wilde Mathews & Christopher Weaver, *Insurers Face New Pressure Over Limited Doctor Choice*, WALL ST. J., Feb. 6, 2014; Howard, *supra* note __, at 592 ("States are … stepping up enforcement of existing network-adequacy requirements and considering new restrictions on insurers' networks.").

[293] *See* Anemona Hartocollis, *New York Curbs Medical Bills Containing Surprises*, N.Y. TIMES, Mar. 30, 2014.

[294] *See* Robert Pear, *To Prevent Surprise Bills, New Health Law Rules Could Widen Insurer Networks*, N.Y. TIMES, July 19, 2014.

insurers,[295] sixteen states have moved over the past decade to enact legislation establishing "all-payer claims databases."[296] The state laws vary along important dimensions—participation is voluntary in some and mandatory in others—but they all aim to give policymakers a sense of the prices that hospitals and other providers actually charge.[297] In this, the new databases are reminiscent of state oversight schemes from the 1970s that allowed state officials to monitor hospital rates.

Most significantly, rate-setting has assumed a new prominence in the policy debates. Leading health economists—including Joseph Newhouse,[298] Stuart Altman,[299] and David Cutler,[300] among others[301]—

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[295] *See* White et al., *supra* note 28, at 324.

[296] *See* Patrick Miller & Ashley Peters, *All-Payer Claims Legislation: Review of Practices*, Nov. 2013, available at https://apcdcouncil.org/sites/apcdcouncil.org/files/APCD%20Council_APCD%20Legislation_November%202013.pdf.

[297] *See* Denise Love et al., *All-Payer Claims Databases: State Initiatives to Improve Health Care Transparency*, at 2 (Sept. 2010), available at http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Sep/1439_Love_allpayer_claims_databases_ib_v2.pdf.

[298] *See* Joseph P. Newhouse, *Assessing Health Reform's Impact on Four Key Groups of Americans*, 29 HEALTH AFF. 1714, 1724 (2010) ("Despite all of the substantive and political problems of price setting, some sort of all-payer regulatory regime may be the only feasible alternative.").

[299] *See* Stuart Altman, Testimony Before the Senate Committee on Finance, *Financing Comprehensive Health Care Reform*, May 12, 2009, at 4, at http://www.finance.senate.gov/imo/media/doc/Stuart%20Altman.pdf ("I would recommend that the federal government encourage more states to establish all-payer systems … .").

[300] *See* Cutler & Morton, *supra* note 41, at 1969 ("A third approach, if there is no other way to obtain good care except through monopoly organizations, is for policy makers to regulate prices or total spending.").

[301] *See* Jonathan Skinner et al., *The 125 Percent Solution: Fixing Variation in Health Care Prices*, HEALTH AFF. BLOG, Aug. 26, 2014, at http://healthaffairs.org/blog/2014/08/26/the-125-percent-solution-fixing-variations-in-health-care-prices/; Anna Sommers et al., *Addressing Hospital Pricing Leverage through Regulation: State Rate Setting*, Policy Analysis from the National Institute for Health Care Reform (May 2012), at http://www.nihcr.org/1tl92; Robert Murray, *The Case for a Coordinated System of Provider Payments in the United States*, 37 J. HEALTH POL. POL'Y & LAW 679 (2010);

have, with varying degrees of enthusiasm, raised the possibility of shifting to an all-payer approach to rate regulation. Its most avid proponent, Uwe Reinhardt, believes the health care system is at "a clearly delineated crossroads":

> On one road, Americans would seek better control over national health spending through an all-payer approach, such as the one operated by Maryland for the hospital sector. On the other road, Americans would seek better control of health care prices and national health spending through greater reliance on market forces for most of the health system. … The battle over US health policy in the coming decades is likely to be over which road to take.[302]

Interest in rate-setting is not confined to commentators. Maryland, for example, has recently announced it will strengthen its all-payer system in an effort to hold cost growth to roughly the rate of economic growth over the next five years.[303] Because the Maryland system has done much to limit costs per admission but little to reduce the number of admissions per patient,[304] the state's new plan will establish fixed budgets for hospital systems keyed to the overall patient population.[305] Those fixed

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Paul B. Ginsburg, *All-Payer Rate Setting: A Response to a "Modest Proposal" from Uwe Reinhardt*, HEALTH AFF. BLOG, July 24, 2009, at http://healthaffairs.org/blog/2009/07/24/all-payer-rate-setting-a-response-to-a-modest-proposal-from-uwe-reinhardt/; Joseph White, *Cost Control and Health Care Reform: The Case for All- Payer Regulation* (2009), at www.ourfuture.org/files/JWhiteAllPayerCostControl.pdf/.

[302] Reinhardt, *supra* note 1, at 2129.

[303] *See* Centers for Medicare & Medicaid Services, Maryland All-Payer Model, at http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/.

[304] *See* Robert Murray, *Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience*, 28 HEALTH AFF. 1395, 1399 (2009) ("[A]lthough costs per admission were well controlled, the same cannot be said for hospital admissions and overall hospital volume.").

[305] *See* Maryland Department of Health and Mental Hygiene, Proposal to the Center for Medicare and Medicaid Innovation, at 9 (2013), available at http://dhmh.maryland.gov/docs/Final%20Combined%20Waiver%20Package%20101113.pdf.

budgets will put pressure on the systems to reduce not only the costs of care, but also the amount of care they provide. (In this, the Maryland plan resembles New York's first efforts at rate-setting in the 1970s.[306]) As the federal government explained in announcing a partnership with the state, "the Maryland system may serve as a model for other states interested in developing all-payer payment systems."[307]

The trend toward a greater acceptance of the public utility model is nowhere more apparent than in Massachusetts. Because the state addressed the insurance crisis in 2006—four years before the ACA was enacted—it has had a longer period of time to train its attention on other weaknesses in the private health-care system. In a series of enactments culminating in the 2012 adoption of the most ambitious cost-control legislation in the country, Massachusetts has edged much closer than is commonly appreciated toward treating medicine as a public utility.

For starters, the state has put health planning at the center of its new approach. The 2012 law establishes a "health planning council" to catalog "the location, distribution and nature of all health care resources in the commonwealth" and develop "recommendations for the appropriate supply and distribution" of those resources.[308] The goal of the health plan is "to rationally distribute health care resources across geographic regions of the state based on the needs of the population on a statewide basis, as well as, the needs of particular geographic areas of the state."[309]

Massachusetts has also taken steps to more closely monitor provider charges. The state established an all-payer claims database in 2008 and, in 2012, expanded the database to require a wider range of data from a broader set of providers about their organizational structure and finances.[310] The 2012 legislation also created a new entity—the Health Policy Commission—and invested it with authority to oversee state

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[306] *See supra* notes 261-62 and accompanying text.

[307] Centers for Medicare & Medicaid Services, Maryland All-Payer Model, at http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/.

[308] 2012 Mass. Session Laws ch. 224, Sec. 14, §16T(b).

[309] *Id*. Sec. 14, §16T(b).

[310] *See id*. Sec. 19, §§9, 10(b); 2008 Mass. Session Laws ch. 305, Sec. 3, §16K(a)

spending targets. Should the state fail to meet its target in a given year, the Commission can review the business practices of any provider with "excessive expenditures."[311] Even more significantly, each provider in the state must inform the Commission before making any meaningful changes in its operations or governance structure.[312] If the Commission concludes that a change will impair the state's ability to meet its spending target, it can undertake a "cost and market impact review" and, where necessary, refer the provider to the Attorney General for an investigation into potential antitrust violations.[313]

Recent experience suggests that the Commission is no paper tiger. Earlier this year, it rebuked Partners HealthCare, Massachusetts' largest hospital system, over its proposed acquisition of a hospital system and physician network.[314] Believing that the acquisitions would increase the hospital system's market power, the Commission referred Partners to the Attorney General for possible action.[315] In mid-May, the Attorney General announced that she had entered into a plea agreement with Partners that would allow it to proceed with its acquisitions. In exchange, Partners agreed to rudimentary price controls: it promised (among other things) not to raise costs above the rate of inflation for the next six years.[316]

Massachusetts has thus made a considered effort to oversee supply, to reduce discriminatory pricing, and to control costs. In this, Massachusetts' efforts bear the imprint of public utility regulation. By no means has the state unequivocally endorsed the public utility model for regulating medicine: the new legislation is in many respects tentative,

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[311] *See* 2012 Mass. Session Laws ch. 224, Sec. 19, §18.

[312] *See id*. Sec. 15, §13(a).

[313] *See id*. Sec. 15, §13(h).

[314] *See* HEALTH POLICY COMMISSION, REVIEW OF PARTNERS HEALTH CARE SYSTEM'S PROPOSED ACQUISITIONS OF SOUTH SHORE HOSPITAL AND HARBOR MEDICAL ASSOCIATES (Feb. 19, 2014).

[315] *See id*. at 59.

[316] *See* Martha Bebinger, *AG Inks Deal to Rein in Partners HealthCare, but Does It Go Far Enough?*, WBUR'S COMMONHEALTH, May 20, 2014, at http://commonhealth.wbur.org/2014/05/partners-south-shore-ag-deal.

particularly when it comes to the enforcement of statewide spending targets. But Massachusetts may be a leading indicator of a broader trend.

CONCLUSION

In 1980, the Institute of Medicine published a report titled *Health Planning in the United States: Issues in Guideline Development*.[317] Prepared in the heat of a transformational presidential election by a committee of nationally renowned experts, the report's fervent embrace of health planning reflected the then-prevailing consensus that such planning was, and would continue to be, central to the development of the health-care market.

The only discordant note came from committee member Clark Havighurst, an early and avid proponent of the turn to market-oriented strategies in health care. Havighurst offered a separate statement that amounted to a dissent: "My own preference is for restoring competition to a dominant resource-allocation role. The committee acknowledges the existence of this point of view but minimizes its realism. Nevertheless, it is an idea whose time may well be coming."[318]

Havighurst proved prescient. In health care, as in other sectors, the 1980s marked a shift away from regulation and toward the market. In building on the private insurance market and pinning its cost-control hopes on managed competition, the ACA may mark the culmination of that trend.

Thirty-four years after Havighurst penned his dissent, the public utility model is now the idea whose time may be coming. In so arguing, I do not mean to minimize how hard it would be to regulate medicine as a utility. Nor do I discount the risks of such an approach. But the familiar objections to public utility regulation—its susceptibility to domination by powerful interests, its inefficiency, the intrinsic difficulty supervising a complex market—may come to seem, in time, less like reasons to dismiss it than as challenges to be managed. If so, the urgent question wouldn't

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[317] *See* INSTITUTE OF MEDICINE, *supra* note 186.

[318] *Id*. at A3 (statement of Clark C. Havighurst).

be whether to treat medicine as a utility. It would be how to assure that the agencies charged with overseeing the medical marketplace have the authority, expertise, and independence to do their jobs.

I could of course be wrong about all of this. Maybe the pendulum is not swinging back; maybe the ACA's market-oriented approach will prove both workable and durable. Whatever happens, however, the public debate remains much too dismissive of a mode of regulation, deeply rooted in the American tradition, that has long been used to tame the unruly market for health care.